

Summary Program Description

For the

Schools Risk and Insurance Management Group Health and Welfare Program

(Nevada County Superintendent of Schools)

**As Amended and Restated
Effective as of July 1, 2020**

This document together with the Certificates of Coverage or the Plans and other documents identified in this document constitutes the Summary Program Description.

Foreword Message from Schools Risk and Insurance Management Group

This Summary Program Description is for employees of Nevada County Superintendent of Schools only. Separate Summary Program Descriptions apply to employees of:

- Ackerman Elementary School District
- Auburn Union School District
- Alta Dutch Flat Elementary School District
- Chicago Park School District
- Clear Creek Elementary School District
- Colfax Elementary School District
- Dry Creek Joint Elementary School District
- Eureka Union School District
- Foresthill Union School District
- Harvest Ridge Cooperative Charter School
- Loomis Union School District
- Mid Placer Public Schools
- Nevada City School District
- Newcastle Elementary School District
- Placer Academy
- Placer County Office of Education
- Placer Hills Union School District
- Placer Union High School District
- Pleasant Ridge Union School District
- Rocklin Unified School District
- Roseville City School District
- Roseville Joint Union High School District
- Schools Risk and Insurance Management Group
- Twin Ridges Elementary School District & Twin Ridges Charter School District
- Union Hill School District
- Western Placer Unified School District

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SUMMARY PROGRAM DESCRIPTION
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Introduction

Schools Risk and Insurance Management Group (the “Contract Administrator” or “Program Administrator”) hereby amends and restates in its entirety the Schools Risk and Insurance Management Group Health and Welfare Program (the “Program”). The Program’s purpose is to combine in one program document provisions of the health and welfare benefit plans (the “Plans”) sponsored by Schools Risk and Insurance Management Group, and to provide uniform administration of these health and welfare benefits. The Plans are listed in **Appendix A** to this Summary Program Description (“SPD”). This SPD reflects and summarizes the terms of the Program in effect on July 1, 2020. Employees of Participating Districts, Ackermann Elementary School District, Auburn Union School District, Chicago Park School District, Clear Creek Elementary School District, Colfax Elementary School District, Dry Creek Joint Elementary School District, Eureka Union School District, Foresthill Union School District, Loomis Union School District, Mid Placer Public Schools, Nevada City School District, Nevada County Superintendent of Schools, Newcastle Elementary School District, Placer Academy, Placer County Office of Education, Placer Hills Union School District, Placer Union High School District, Pleasant Ridge Union School District, Rocklin Unified School District, Roseville City School District, Roseville Joint Union High School District, Twin Ridges Elementary School District, Twin Ridges Charter School District, Union Hill School District, Western Placer Unified School District, Harvest Ridge Cooperative Charter School and Alta Dutch Flat Elementary School District, are eligible to participate in the Program. Participating Districts may be added or changed from time to time.

The insurance contracts (including Certificates of Coverage), summary plan descriptions, policies and procedures, and any other documents making up the Plans are not affected by the adoption of the Program, and

the terms of the Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts (if any) or similar arrangements.) The terms of each Plan are incorporated into this SPD by reference and will continue to act as the primary source of information for each Plan. However, if a conflict of language exists between the Plan and the Program or SPD, the Plan will control as long as the Plan is not inconsistent with Federal law and regulations. The exception is, regardless of a Plan’s identification of a Program Year or Program Number, the Program Year or Program Number of this SPD will control.

Note: Every effort has been made to accurately describe the Program in this SPD. However, if there should be a discrepancy between the SPD and the Program document -- or if the Program is required to operate in a different manner to comply with Federal laws and regulations -- the Program document or the appropriate Federal laws and regulations will control.

If you have not received a Certificate of Coverage (which also may be known as a certificate of insurance or evidence of coverage) or other document that summarizes in detail a Plan, you may request the Certificate of Coverage or other document which will be made available by the Plan Administrator (identified under the heading "Plan Administrator") to you or your beneficiaries without cost.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address or email and the addresses of any family members who are covered by the Program.

General Information Pertaining to the Program

Program Name, Sponsor and Employer EIN

The name of the Program is Schools Risk and Insurance Management Group Health and Welfare Program. Schools Risk and Insurance Management Group is the Program Sponsor. The Program Administrator's address is 550 High Street, #201, Auburn, CA, 95603. The Program Administrator's telephone number is 800-442-4199. The Program Administrator's Federal employer identification number (EIN) is 68-0074971.

Program Year

For recordkeeping purposes, the Program Year for the Program is the 12 month period beginning on July 1 and ending June 30.

Program Number

The number of this Program is 501.

Type of Welfare Benefit Plan(s)

The Program may provide various welfare benefits under the Plan(s) listed in **Appendix A** to this SPD.

Funding

Benefits under the Program are funded by one or more of the following methods selected by Schools Risk and Insurance Management Group for a Plan: insured benefits, self-funded benefits, or a combination of insured benefits, self-funded benefits and trust benefits. Funding for the Program will consist of the funding for all Plans and may include funding through a cafeteria plan.

Schools Risk and Insurance Management Group has the right insure any benefits under the Program, and establish any fund or trust for the holding of contributions or payment of benefits under the Program, either as mandated by law or as Schools Risk and Insurance Management Group determines advisable in its sole

discretion. In addition, Schools Risk and Insurance Management Group has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Program, including, but not limited to, any trust or insurance policy. If any benefit or portion of the benefit is funded by the purchase of insurance, the benefit or portion of the benefit will be payable solely by the insurance company.

Plan Administrator

The Plan Administrator is Nevada County Superintendent of Schools, which, for insured benefits offered through the Program, administers the Plans with the insurance companies providing benefits under the Plans as named fiduciaries. The insurance companies are responsible for considering, accepting or denying, and paying claims for the insured benefits. The indicated insurance company is responsible for considering any appeals to the insured benefits made following a Plan's claim procedures and, if applicable, the claim procedures indicated in this SPD.

Agent for Service of Legal Process

The agent for service of legal process is Schools Risk and Insurance Management Group, 550 High Street, #201, Auburn, CA, 95603. Service may also be made on the Plan Administrator.

Named Fiduciary

The Contract Administrator is the primary named fiduciary of the Program and has the exclusive and express discretionary authority to interpret the terms of the Program and the terms of all the Plans to the extent not delegated to another named fiduciary. For insured Plans, the insurance company is also a named fiduciary under the Program as to the determination of the amount of, and entitlement to, insured benefits with the full power to interpret and apply the terms of the Program as they relate to the benefits provided under the insurance policy.

[Insurance Company Refund](#)

As to any insurance company refund/rebate received by Schools Risk and Insurance Management Group that is subject to the Medical Loss Ratio (“MLR”) provisions of the Patient Protection and Affordable Care Act of 2010 (the “Affordable Care Act” or “ACA”) and the further guidance provided by Department of Labor Technical Release 2011-04, the Contract Administrator will determine what portion (if any) of such rebate must be treated as “Program assets” (note that MLR provisions do not apply to self-funded plans). If any portion of the rebate must be treated as “Program assets,” the Contract Administrator will determine, in its sole discretion, the manner in which such amounts will be used by the Program or applied to the benefit of the Participants (the Participants need not be the same as those who made contributions under the policy that issued the rebate). Any portion of the rebate that is not treated as a ‘Program asset’ will be allocated to any employer or, if applicable, among one or more employer(s) as the Program Sponsor in its sole discretion determines appropriate. If the rebate is applied toward a benefit enhancement or as an offset to participants’ share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the participants’ share of premiums be reduced over a period of months) should be provided in a written policy.

[Program Document](#)

The Program and those documents incorporated by reference in the Program compose a written employee benefit welfare plan.

[Coverage for Spouses, Dependents, and/or Domestic Partners](#)

One or more Plans covered under the Program may identify spouses, dependents/children, domestic partners and others as eligible non-employee participants. The provisions relating to that coverage should be detailed in the

Certificates of Coverage or other Plan documents. Note that you have an obligation to notify the Employer promptly of any loss of dependent status.

If you want to enroll your domestic partner, you should ask at the time of enrollment elections what information is necessary to apply, including any affidavit and/or other documentation required by the Plan Administrator. Contact the Plan Administrator if you have questions.

[No Guarantee of Non-Taxability](#)

The Program provides benefits often intended to be non-taxable. The Contract Administrator or any fiduciary or party associated with the Program will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

[No Guarantee of Employment](#)

The offering of the Plans under the Program is not a commitment or guarantee of employment by any Employer and does not affect any Employer’s rights to discharge any employee.

[Nondiscrimination](#)

Contributions and benefits under the Program will not discriminate in favor of "highly compensated employees" or "key employees" as such terms are defined under the Code. The Employer may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

[Anti-Assignment](#)

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Program and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the participant and shall not constitute an assignment of benefits under the Program.

Eligibility, Participation and Benefits

Eligibility and Participation

Eligibility for participation and benefits under the Program is determined under the written terms of the Program and each Plan. See a summary of more information regarding eligibility and participation in **Appendix A**.

If you previously participated in the Program and are rehired, you will be eligible to become a Participant on the same terms as if you were a newly hired employee. However, in most instances, group health plans offered by an “applicable large employer” (generally, an employer that employs an average of at least 50 full-time employees (including full-time equivalent employees)) are subject to the Affordable Care Act and have special rehire rules. These rules are as follows: if your Employer is subject to the ACA and you return to work after a period during which you were not credited with any hours of service, you may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply: (i) you had no hours of service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) you had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of your period of employment. These provisions are intended to comply with the ACA and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

If your Employer believes it is an “applicable large employer” under the ACA, it may elect to take advantage of the look-back provisions of the ACA. See **Appendix B** for details.

Insurance carriers sometimes impose an “actively at work” requirement for certain types

of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. This requirement would be reflected in your Certificate of Coverage. This may also be the case in which you are rehired as an employee.

Note that the “actively at work” requirement does not apply to a Group Health Plan (other than one offering only HIPAA-excepted coverage) unless there is an exception for individuals who are absent from work due to a health factor (e.g., individual is out on sick leave on the day the coverage would otherwise become effective).

As to any Plan that is a group health plan (other than one offering only HIPAA-excepted coverage), any otherwise eligible employee must wait no longer than ninety (90) days to begin coverage under such Plan.

Contributions

The cost of the benefits provided through the Plans may be funded in part by Employer contributions and in part by your contributions. In some instances, a Plan may require only you or the Employer to contribute. The cost of benefits provided through a Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. Your Employer will determine and periodically communicate your share of the cost of the benefits provided through each Plan, and it may change that determination at any time. Your Employer will make any contributions in an amount that in the Contract Administrator’s sole discretion is at least sufficient to fund the benefits. Schools Risk and Insurance Management Group will pay its contribution and your contributions to an insurance company or, for benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members. Where relevant to a Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Plan is adjusted

during the Program Year, you will be notified of that adjustment unless the Plan provides otherwise.

The Contract Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual, organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Program consist of the benefits available under the Plans, including all limitations and exclusions for each Plan's benefits. The benefits available under each Plan are set forth in the Plan documents. The availability of benefits is subject to your payment of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Plan..

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), you will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a benefit document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what circumstances coverage is provided for emergency and out-of-network services.

Loss of Benefits

Your benefits (and the benefits of your eligible dependents) generally will cease when your participation in the Program terminates. Benefits will also cease upon termination of the Program. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents of the Plans provide

additional information. The subrogation provisions of the Program are discussed in more detail in the section "Contract Administrator's Right of Reimbursement."

Benefit Elections

Electing Your Benefits for the Program Year Under a Plan

Some of the Plans may require you to make an annual election to enroll for coverage for the next plan year prior to the beginning of that year. The plan year for each Plan should be set forth in that plan and may be different than the Program Year for this Program. Thus, the discussion below regarding plan year refers to the relevant Plan's plan year.

If you first become eligible to participate in a Plan during a plan year in progress, your initial elections pertain to the remaining part of that plan year. Then, before each new plan year begins, you will have an opportunity to change or cancel your elections during the annual open enrollment period. The annual open enrollment period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Plan. You may also elect not to participate in a Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form in a format approved by the Plan Administrator (whether in paper or electronic format) before the end of the annual open enrollment period. When you make your elections, you also authorize the necessary payroll deductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Program, if you become eligible for additional benefits during a plan year, you will be given an

opportunity to elect and enroll in the benefits for which you are newly eligible.

Annual Election Period

Before the beginning of each plan year, the Plan Administrator often may hold an annual open enrollment period. In that case, the Plan Administrator will notify you when the dates for the annual open enrollment period will occur each year. During this time, you may make new elections for the upcoming plan year. Your elections from the prior year may roll forward to the current year. You should consult with material provided to you during the annual open enrollment period to determine whether an election is required.

Changing Your Elections during a Plan Year

Where a Plan is funded through a cafeteria plan, once you have made your elections for a plan year, it pertains to the entire plan year as it applies to that Plan and cannot be changed or cancelled during that time except in certain limited situations that are described in the cafeteria plan. Other election restrictions may apply to Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Plan.

If you, your spouse, or your dependent child experience a "change in status," and that change in status makes you, your spouse, or your dependent child eligible or ineligible for any of the pre-tax benefits, or for any of the benefit options sponsored by your spouse's or your eligible dependent child's employer, you may change the amount of your election in a way that is consistent with that "change in status," provided you notify the Plan Administrator of such change within 30 days (or, for some employers, 31 days) of such change. The determination of whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such an event shall be made in the sole discretion of the Plan Administrator.

These rules also apply to a spouse and other individuals such as a domestic partner under certain circumstances.

A "change in status" includes a change in the following:

- (a) marriage;
- (b) other changes in your legal marital status (for example, your divorce, annulment, or legal separation, or the death of your spouse);
- (c) birth or adoption of a child, including placement for adoption;
- (d) other changes in the number of your dependents (for example, legal guardianship for a child);
- (e) you, your spouse's or your dependent child's employment status (for example, terminating or beginning a job; changing the number of hours worked, such as switching from full-time to part-time, or vice versa);
- (f) you, your spouse or your dependent child begins or returns from certain types of unpaid leave of absence (FMLA or USERRA) or change in worksite;
- (g) your dependent satisfies or ceases to satisfy eligibility requirements (for example, attainment of the limiting age, loss of student status, or similar circumstances);
- (h) your (or your spouse's or dependent's) residence that results in gaining or losing eligibility for a health care option (such as moving out of an HMO service area); and
- (i) any other event specified under the Employer's cafeteria plan that is consistent with IRS regulations and pronouncements, such as the specific situations related to the availability of coverage through a Health Insurance

Exchange (or Marketplace) as provided in IRS Notice 2014-55, which allows prospective revocation of the employee's election under certain circumstances.

(a) A power of attorney for health care purposes, notarized by a notary public;

(b) A court order of appointment of the person as the conservator or guardian of the individual; or

(c) An individual who is the parent of a minor child.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a TPA must be filed in accordance with the specific procedures contained in the insurance policies, Plans or the third party administrative services agreement. The name (and in the case of group health plan claims, the address) of the individual insurance company providing benefits and reviewing claims relating to its insurance policy is set forth in **Appendix A**. Further, the name of the TPA (if any) that reviews claims made under a Plan may be set forth in **Appendix A**. All other general claims or requests should be directed to the Contract Administrator.

Personal Representative

You may exercise your rights directly or through an authorized personal representative. You may only have one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

Your personal representative will be required to produce evidence of their authority to act on your behalf. The Program may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information or allowed to take any action for you. (A mere assignment or attempted assignment of your benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Program.) This authority may be proved by one of the following:

The Program retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General Claims Procedure

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Program (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

The Program's claims procedures are described below. (These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") or to any dependent care assistance plan offered.)

The following procedures will be followed for denied claims under a Plan that is not a group health plan or disability plan. For group health claims and disability claims, see headings "Special Rules for Group Health Plan Claims" and "Special Rules for Disability Claims."

(a) If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. Under special circumstances, the Claim Fiduciary may take up to an additional 90 days to review the claim if it

determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The written notification of a denied claim for benefits will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

(b) Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Contract Administrator or its delegate such as the insurance company or TPA, which includes the reasons why you feel the claim is valid and the reasons why you think the claim should not be denied. Before submitting an appeal request, you may request to examine and receive copies of all documents, records, and other information relevant to the claim. If you fail to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Documents, records, written comments, and other information in support of your appeal should accompany any appeal request. The Contract Administrator or its delegate will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Contract Administrator or its delegate due to matters beyond its control.

If an extension of time is required, you will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Contract Administrator or its delegate expects to render a decision. The Contract Administrator's response (or its delegate's) will explain the reason for the decision with specific reference to the provisions of the Program on which the decision is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement about your right to bring a civil action.

(c) The Contract Administrator or its delegate has the sole discretion to interpret the appropriate Program provisions, and such decisions are conclusive and binding.

(d) To the extent not inconsistent with the provisions of the applicable Plan, with respect to any civil action brought under the Program, a claimant will be barred from bringing such civil action after one year from the date of exhausting the Program's claims procedures relating to the denial of the claim. In the case of a group health plan claim discussed below, this includes not only exhausting the Program's internal claims procedure but also exhausting the Program's external claims procedure, where applicable.

Special Rules for Group Health Plan Claims

There are four categories of claims under a Plan that is a group health plan (e.g., medical, dental, vision, health care flexible spending account and EAP benefits), and each one has a specific timetable for approval, request for additional information, or denial of the claim. The four categories of claims are:

Urgent Care Claims - a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to

regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition or an insurance company or TPA (applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine) may determine if a claim is an Urgent Care Claim.

Pre-Service Claims - a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

Post-Service Claims - a request for payment for covered services you have already received.

Concurrent Care Claims – a request to extend an ongoing course of treatment beyond the period of time or number of treatments that has previously been approved under the Program.

(a) Time for Decision on a Claim. The time deadline for making decisions on claims under the Program depends on the category of the claim. (See Time Limit Chart below for maximum time limits.) You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written notice will be provided to you within three days.

Note that fully-insured plan claims (if any) may be subject to an even more accelerated response time by the insurance company handling the claim. See Certificates of Coverage for details.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from you will be sent within the timeframes shown in the chart below and will specify what information is needed. You must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The

determination period will be suspended on the date the Claim Fiduciary sends a notice of missing information and the determination period will resume on the date you respond to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension that you receive will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied. The notice will contain the following information:

- (1) the specific reason or reasons for the adverse determination;
- (2) reference to the specific plan provisions on which the determination was made;
- (3) a description of any additional material or information necessary to perfect your claim and an explanation of why this material or information is necessary;
- (4) a description of the Program's review procedures and the time limits that apply to these procedures, including a statement of your right to

bring a civil action if your claim is denied on review;

(5) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;

(6) if an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request; and

(7) if the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Program Fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you in writing to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal such denial. If you fail to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be

made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review must contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Program to review your appeal request and to notify you of its decision depends on the type of claim as follows:

Urgent Care Claim – 72 hours; you will be notified orally and written notice will be provided within three days.

Pre-Service Claim – 30 days if the Plan provides for only one mandatory appeal; 15 days for each appeal if the Plan provides for two mandatory appeals.

Post-Service Claim – 60 days if the Plan provides for only one mandatory appeal; 30 days for each appeal if the Plan provides for two mandatory appeals.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether that information was submitted or considered in the initial claim determination. The review will be conducted by a Program Fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training

and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Program Fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review. The notice will contain the following information:

- (1) the specific reason or reasons for the denial;
- (2) specific references to the pertinent plan provisions on which the denial is based;
- (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- (4) a statement about your right to bring a civil action following any final adverse benefit determination;

(5) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(6) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Fiduciary will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to your medical circumstances; and

(7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Also, upon request, the Claim Fiduciary will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Time Limit (Group Health Plan Claims)	Urgent Care*	Pre-Service*	Post-Service*
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Program's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days

* The Claim Fiduciary will decide the appeal of "Concurrent Care Claims" within the time frame set forth above depending on whether that claim is also an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Fiduciary.

Special Internal Appeals Review Procedures Under the Affordable Care Act

Under the ACA, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage of the Program based upon, generally whether the Program is (1) fully-insured or (2) self-funded for any "Adverse Benefit Determination" (i.e., any medical claim or any claim involving a rescission of coverage).

- (a) A rescission is allowed only upon a finding of fraud or intentional misrepresentation of a material fact;
- (b) You must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Program in connection with the claim. It must also provide you with any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to the new evidence or rationale;
- (c) Decisions regarding hiring, compensation, termination, promotion,

or other similar matters with respect to an individual by a claims adjudicator or medical expert may not be based on the likelihood that that person will support the denial of benefits due to that influence (this prohibition is to avoid conflicts of interest);

(d) Notices to claimants by the Program or Claim Fiduciary must also include additional content as follows:

- (1) Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon your request, the diagnosis code and treatment code and their corresponding meanings will be provided as soon as practicable.
- (2) Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a

description of the Program's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

(3) A description of available internal appeals and external review processes, including information about how to initiate an appeal.

(4) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

(5) Notices of any Adverse Benefit Determination must be in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any claimant in the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in that other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Program or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide

assistance with filing claims and appeals.

(e) Generally, the Program's or Claim Fiduciary's failure to adhere to the requirements of the ACA will allow you to deem the internal claims and appeals process "not in compliance" under the ACA, therefore declaring your claim procedure "exhausted."

You may appeal this determination by requesting external review described in more detail, below.

Special State External Appeals Review Process Under the Affordable Care Act

You should be aware that the Department of Labor ("DOL") has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination that involves medical judgment (including, but not limited to, a determination regarding medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at this time), relating to *insured health benefits* (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules). Please refer to the external appeals table identified here: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

(a) A State may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections;

(b) A State may operate an external review process under "similar standards" to those outlined in the July 2010" interim final rule (These "similar

standards" apply until January 1, 2018); or

(c) Where the State meets the "strict standards" or the "similar standards," your health plan is subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to you by the insurance company or the Program.

Special Federal External Appeals Review Process Under the Affordable Care Act

Generally, plans that are either *self-funded* (are not provided through insured health benefits) or *have not elected or are not eligible to qualify for the State review external appeals process* for any Adverse Benefit Determination are subject to Federal review process described below.

(a) You will have four months after the day you receive notice or are deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination.

(b) The Program or Claim Fiduciary has five business days from the date a claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether you were covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully.

(c) Within one business day after the preliminary review, the Program or Claim Fiduciary will notify you in writing of its decision. If the claim is complete

but not eligible for external review, you will be provided with the reason for its ineligibility and as well as contact information for the Employee Benefits Security Administration. If the claim is incomplete, you will be provided with an explanation of what is necessary to complete the claim and the Contract Administrator or Claim Fiduciary must give you a reasonable time to complete the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompleteness).

(d) If you appeal an appealable final internal adverse benefits determination (or challenge whether or not it is appealable), your claim must be referred to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct external reviews. The referral will occur through an unbiased selection process involving several IROs.

(e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days after the IRO receives the assignment.

(f) If the IRO reverses the decision of the Program or Claims Administrator, your payments or coverage must begin immediately, even if the Program or Claims Administrator expects to appeal it to a court of law.

(g) You must also have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after

its receipt of the request. If the IRO's notice of its determination is not provided in writing within 48 hours after the date of providing that notice it must provide written confirmation to you and the Program.

(h) The contracts with the IROs must include the requirements contained in the DOL Technical Releases, and the IROs must agree, among other things, to the following: de novo review of all information and documents timely received (including the Program document, claims records, health care professional recommendations, and clinical review criteria used, if any), retaining its records for six years and making them available to the applicable claimant (or to State and Federal government agencies, to the extent not in violation of any privacy laws) for examination upon request, and inclusion of certain information in notices to claimants.

The Program intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA and the provisions herein should be interpreted accordingly.

Special Rules for Disability Claims

Schools Risk and Insurance Management Group does not offer a disability plan at this time. The language below will apply if and when such a plan is implemented.

A disability claim requires the Program to determine if you are disabled for purposes of eligibility for disability benefits under a Plan. Except as provided under this heading, the general claims procedures under the heading "General Claims Procedure" apply, including but not limited to the provisions relating to any Program Fiduciary's rights and responsibilities as provided in paragraph (c) under the heading "General Claims Procedure" and the claims limitation

period identified in paragraph (d) under the heading "General Claims Procedure".

Time for a Decision on a Disability Claim

The Program will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Contract Administrator. If the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension you receive will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. If more information is requested during either extension period, you will have at least 45 days to supply it.

Notification of Denial

The Program will notify you of its initial claim determination in accordance with the procedures described in paragraph (b) under the heading "Special Rules for Group Health Plan Claims".

How to Appeal a Disability Claim

You may appeal the Program's determination within 180 days following receipt of an adverse determination in accordance with the procedures described in paragraph (c) under the heading "Special Rules for Group Health Plan Claims". The Program will notify you of its determination on review within 45 days and in accordance with the procedures in paragraph (b) under the heading "General Claims Procedure." Otherwise, the general claims procedures apply, including the provisions relating to any Program Fiduciary's rights and responsibilities and the claims limitation period. Under special circumstances, the Claim Fiduciary may take up to an additional 45 days to review the claim if it

determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. You have at least 45 days to provide the specified information.

Notification of Benefit Determination on Review

You will receive written notice of the Program's benefit determination on review that sets out the information below in accordance with paragraph (c) "How to Appeal a Denied Group Health Plan Claim."

Coverage While on Leave of Absence

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Family and Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to public agencies. FMLA also requires you to have worked a certain number of hours and months in order to be eligible. If you have questions about whether or how FMLA applies to you, you should contact the Plan Administrator for more details. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires public agencies to provide up

to 12 weeks of unpaid, job-protected leave to eligible employees. This family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee's job.

FMLA was expanded for an eligible employee's parents or immediate family members being called to active military duty status or in active military duty in the following ways: (1) the events for triggering family leave now include "qualifying exigencies" of covered service members. (See your Employer for details.) and (2) eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period care for covered service members with a serious injury or illness.

If you are eligible and choose to take FMLA leave, your public agency must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Any changes to the group health plan during the time you are on FMLA leave apply to you. Your public agency must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your public agency has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you will no longer be covered, but upon your return to employment, the public agency is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical

necessity, then you may be required to reimburse your public agency for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your public agency cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when a public agency's obligation to maintain health benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

[Military Service Leave \(USERRA Coverage\)](#)

Any participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") will continue to participate and be eligible to receive benefits under any Plan that is a group health plan in accordance with USERRA rules and regulations.

Group health plans and health insurance issuers, under USERRA, must protect all

persons who perform duty, voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- (a) you held the job prior to service;
- (b) you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- (c) your cumulative period of service did not exceed five years;
- (d) you were not released from service under dishonorable or other punitive conditions; and
- (e) you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- (a) for less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- (b) for 31 to 180 day of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or

unreasonable through no fault of your own, then as soon as possible;

(c) for 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;

(d) for service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

If you were covered under a Plan which is a group health plan immediately prior to taking a leave for service in the uniformed services, you may elect to continue your coverage under USERRA for certain periods required under USERRA, if you pay any required contributions toward the cost of your group health plan coverage during the leave. Any USERRA continuation coverage you elect will end earlier if one of the following events takes place:

(a) You fail to make a premium payment (or premium equivalent) within the required time;

(b) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

(c) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or fewer, your contribution amount will be the same as for active employees, as long as you remain an active employee. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled “Other Continuation/Conversion Privileges.” If you elect USERRA coverage, you may not elect

COBRA coverage during your military service. Likewise, if you elect COBRA continuation coverage during your military service, you may not elect USERRA coverage when your COBRA coverage ends.

If your coverage under the Program terminated because of your service in the uniformed services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period required by USERRA. See the Plan Administrator for details.

Certain Federal Rights of Individuals Under Health Plans

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer’s control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Benefits for Adopted Children

If the group health plan under which you are covered provides benefits for dependent children, Schools Risk and Insurance Management Group group health plan will extend benefits to dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Children's Health Insurance Program Reconciliation Act

The Children's Health Insurance Program ("CHIP") was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In the case of group health plans, various amendments to CHIP allow States to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. Each State in which an employee resides will choose whether it will implement this optional subsidy. CHIP also allows for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage.

Generally, if you are eligible, you may be able to enroll in the employer's group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your State has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Generally, where COBRA applies, if you or your eligible family members' group health plan coverage ceases because of certain "qualifying events" specified in COBRA (such as termination of employment for reasons other than gross misconduct, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You may also have coverage continuation rights under State insurance

laws, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Information on State insurance law continuations is contained in the Certificate of Coverage (or its equivalent) which is incorporated by reference in **Appendix A**. As an additional benefit, the Employer may extend to civil union partners, and qualified same-sex domestic partners the rights which may parallel the Federal laws of COBRA ("COBRA-like rights"). It should be noted that any COBRA-like rights offered by an employer presently do not enjoy the same income tax benefits at the Federal level and may not at the State level. This document does not address Federal, State and local tax treatment in detail, and is not intended to provide tax advice. For information on how applicable tax laws may apply to your personal situation, consult your tax adviser. See applicable Certificate of Coverage (or its equivalent) as well as the Plan Administrator (or third-party COBRA administrator, if any) for details.

If you, your spouse, or your dependents lose coverage under the Program because you experience a life event known as a "qualifying event," you and/or your spouse and dependents may be eligible to elect continuation coverage under COBRA for the portions of the Program that are a "group health plan" (e.g., medical, dental, vision, health reimbursement arrangement, telemedicine, expert medical opinion (in some cases) and health care flexible spending account ("health care FSA") benefits).

You, your spouse, or your dependents experience a "qualifying event" under COBRA if your employment terminates (or your hours are reduced making you ineligible for participation) for reasons other than gross misconduct. Additionally, your spouse or your dependents may experience a "qualifying event" due to your

divorce, legal separation, death, or entitlement to Medicare. If you (or your spouse or your dependents) experience one of these qualifying events, and as a result lose coverage under the Program, you (or your spouse or your dependents) may be eligible for COBRA.

To be eligible for COBRA in the event of a divorce or legal separation, or if your dependents become ineligible under the Program, you, your spouse, and/or your dependents must notify the Contract Administrator (or third-party COBRA administrator, if any) as soon as possible after the qualifying event occurs, and no later than 60 days after the qualifying event occurs. You must provide this notice, in writing to the Contract Administrator (or third-party COBRA administrator, if any). In order to protect your rights, you should keep the Contract Administrator (or third-party COBRA administrator, if any) informed of any changes in the address of you, your spouse, and/or your dependents.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends (or after the employer stops contributing toward the other coverage) because of the qualifying event listed below. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Once the Contract Administrator (or third-party COBRA administrator, if any) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has

an independent right to elect COBRA. You may elect COBRA on behalf of your spouse who was covered under the group health plan at the time of the qualifying event, and you or your spouse may elect COBRA on behalf of your eligible dependents that were covered under the group health plan at the time of the qualifying event.

The Contract Administrator (or third-party COBRA administrator, if any) will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after your participation ends or you receive this form, whichever is later. The Program will offer COBRA continuation coverage only after the Contract Administrator (or third-party COBRA administrator, if any) has been notified that a qualifying event has occurred.

When the qualifying event is your death, your entitlement to Medicare benefits, your divorce or legal separation, or a dependent's losing eligibility as dependents, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is your termination of employment or reduction of hours of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries (other than you) may last for up to 36 months after the date of Medicare entitlement. In some situations (described below), COBRA may last up to 29 or 36 months. Otherwise, when the qualifying event is your termination of employment or reduction of hours, COBRA generally lasts for up to a total of 18 months. There are two ways in which the 18 month period of COBRA can be extended:

(a) *Disability Extension.* If you or any of your covered dependents is determined by the Social Security Administration ("SSA") to be

disabled and you notify the Contract Administrator (or third-party COBRA administrator, if any) in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18 month period of COBRA. To be eligible for this disability extension, you must notify the Contract Administrator (or third-party COBRA administrator, if any) of the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month COBRA period. However, if the ruling letter is received before COBRA eligibility begins, the letter must be provided within the first 60 days of electing COBRA. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Contract Administrator (or third-party COBRA administrator, if any) within 30 days after the SSA's determination.

(b) *Second Qualifying Event Extension.* If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependents can get up to 18 additional months of COBRA coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Contract Administrator (or third-party COBRA administrator, if

any) within 60 days of the occurrence of the second qualifying event. This extension may be available to your spouse and dependents receiving COBRA if you die, become entitled to Medicare benefits, get divorced or legally separated, or if your dependent stops being eligible under the Plan as a dependent, but only if the event would have caused your spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

There are a few cases in which a COBRA participant or qualified beneficiary could lose COBRA coverage early. Such person is no longer entitled to COBRA if the participant who becomes covered under another group health plan, fails to make the required contributions on time, becomes entitled to Medicare benefits (under Part A and/or Part B or both, including if someone has also enrolled in Medicare Advantage), or the Employer ceases to provide any health plan benefits.

To continue your group health coverage, you and/or your covered dependents may be charged up to 102% of the full cost of coverage (or 150% in the case of an 11-month extension due to disability). You make this payment monthly during the 18, 29 or 36-month period of continuation coverage. The first premium payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include your COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date. Premium payments should be sent to the Plan Administrator's (or third-party COBRA administrator's, if any) address.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a 'special enrollment period.' Some of these options may cost less than COBRA continuation coverage.

For more information about your rights under COBRA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov/.

COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. In the event any provision of this document, including the applicable Attachments, fails to comply with the requirements of the applicable law or fails to determine the rights or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by the Plan be greater than those required to be provided by COBRA.

[Genetic Information Nondiscrimination Act](#)

The Genetic Information Nondiscrimination Act ("GINA") states that health benefit plans may not discriminate on the basis of genetic information relating to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or "business associate" of the employer. One exception to this rule is that a minimum amount of genetic testing results

may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies genetic information is treated as protected health information under another Federal law called "HIPAA." The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can your Employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

There is an exception to GINA's general prohibition against acquiring you or your family's genetic information where your Employer offers voluntary health or genetic services to employees or their family members. Some employers want to offer inducements for employees and their family members to answer questions about their health or to take medical examinations as part of a wellness program; however, your Employer may only offer a limited incentive for your spouse to provide information about their current or past health status as part of a voluntary wellness program.

[HIPAA Rules](#)

Information you provide for purposes of a health plan sponsored by the Employer may be protected health information under Privacy Standards established under the Health Insurance Portability and Accountability Act ("HIPAA"). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also protected health information. If you have questions about this law, you should contact the Plan Administrator.

Regarding HIPAA portability, some group health plans are subject to HIPAA portability rules while others are not. Group health plans that are generally not subject to

HIPAA portability (and therefore are considered "HIPAA-excepted coverage") include for example certain limited dental and vision plans, as well as long-term care, nursing home care, home health care, or community-based care, specified disease or illness, hospital indemnity or other fixed indemnity, and most FSAs.

In addition, a group health plan that is subject to HIPAA portability must comply with the following:

If a group health plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of that injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Note that pre-existing condition exclusions are now prohibited for group health plans.

[Mental Health Parity Act](#)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits. For example, a plan may not apply separate

deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

To the extent that non-Grandfathered small group plans are required to provide essential health benefits, including mental health and substance abuse disorder benefits, for plan years beginning on or after July 1, 2014, such benefits must comply with the final rules issued by the DOL on November 13, 2013.

[Michelle's Law](#)

Many health plans extend health coverage to dependents of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by the Contract Administrator for continued coverage under the health plan. Group health plans must provide extended coverage to any of the Participant's dependents who is a full-time student in a postsecondary educational institution that would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection under Michelle's Law. The Contract Administrator may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier, the date the coverage would otherwise end under the Plan.

While the Affordable Care Act provision that requires extension of coverage for dependents until the end of the month in which a dependent reaches age 26 will

often make reliance upon Michelle's Law unnecessary, Michelle's Law still will have relevance in certain circumstances such as its applicability to HIPAA-excepted coverage (to which the ACA does not apply).

[Newborns' and Mothers' Health Protection Act](#)

Group health plans 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 the above periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods.

[Qualified Medical Child Support Orders](#)

The Employer's group health plans will provide benefits as required by any qualified medical child support order ("QMCSO"). The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

[Patient Protection and Affordable Care Act](#)

The Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") of 2010 requires the modification of group health plans in a number of ways. Some of these significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for group health plans *that are neither grandfathered nor HIPAA-excepted coverage*:

(a) If you need to receive emergency services in the emergency department of a hospital, you do not need prior authorization, and your cost-sharing obligations (including co-payments and co-insurance) will be the same whether you are treated at a hospital that is in-network or out-of-network. You are not required to receive prior approval as would be applied to care received by preferred providers; however, you may be responsible for the allowed amount under your plan and what is billed by a non-network provider, to the extent permitted by the ACA;

(b) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women;

(c) If your health plan requires you to select a primary care physician ("PCP"), the group health plan or health insurer may designate one for you automatically. In some circumstances, you can designate any participating PCP (who participates in the network and who is accepting new patients) as your PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered dependent child; if the group health plan designates a PCP automatically, until you make this designation, the group health plan or health insurer will designate one for you. Where selection of a PCP is required or allowed, contact the insurer for information on the selection process;

(d) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurer; and

(e) Internal appeal and external review claim procedures are revised as provided in the "Claims Procedures" section of this SPD.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *both grandfathered and non-grandfathered health plans that are not HIPAA-excepted coverage*:

(a) Any lifetime or annual maximum may not be imposed on the following benefits to the extent that they are covered under the Plan: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential

Health Benefits"). For purposes of determining whether a benefit or service is an essential health benefit relating to permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan must choose a benchmark state;

(b) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded; and

(c) If you have elected coverage for your dependents under your health plan, your child (including step-child, legally adopted child, a child placed for adoption and a child under a QMCSO or National Support Notice) can be covered until the end of the month in which a child turns age 26 regardless of the child's tax dependent status.

The above includes certain minimum provisions of the ACA. In certain cases, a Plan's Certificate of Coverage may be more generous than the ACA requires. Therefore, you should review the Certificate of Coverage for details.

[Women's Health and Cancer Rights Act](#)

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the

same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Plan identified in **Appendix A**. Call your Plan Administrator for more information.

Wellness Program

In some circumstances, the Program may offer wellness programs designed to promote the health and well being of all employees. Some examples of wellness programs include, but are not limited to: providing financial incentives to engage in activities that encourage health lifestyle changes, providing you with information about your current health condition by undergoing health screenings or answering questionnaires, giving you the opportunity to receive health coaching, and participating in disease management programs.

These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Employer money.

Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communications.

Under the Americans with Disabilities Act (“ADA”), any wellness program that includes disability-related inquiries or medical examinations for employees must be voluntary, meaning that it may not (i) require any employee to participate; (ii) deny any employee who does not participate in a wellness program access to health coverage or prohibit any employee

from choosing a particular plan; and (iii) take any other adverse action or retaliate against, interfere with, coerce, intimidate, or threaten any employee who chooses not to participate in a wellness program or fails to achieve certain health outcomes. Employers must also provide a notice that clearly explains what medical information will be obtained, how it will be used, who will receive it, and the restrictions on disclosure. Finally, an employer must comply with certain incentive limits. Effective January 1, 2019, these incentive limits have been voided.

Under the ADA, any wellness program must also be reasonably designed to promote health or prevent disease, meaning that it cannot (i) require an overly burdensome amount of time for participation; (ii) involve unreasonably intrusive procedures; (iii) be a subterfuge for violating the ADA or other laws prohibiting employment discrimination; or (iv) require employees to incur significant costs for medical examinations.

Any wellness program related to financial incentives offered under the Program must comply with the requirements and limitations of HIPAA, the ACA, the ADA and related guidance. For example, where a wellness program subject to HIPAA is offered under the Program, a reward may be offered based on certain standards of achievement. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Plan Administrator, and we will work with you to develop another way to qualify for the reward.

Contract Administrator's Rights under the Program

[Contract Administrator's Right to Change or End the Program](#)

Schools Risk and Insurance Management Group reserves the right to terminate, suspend, withdraw, amend or modify the Program, or any Plan, in whole or in part at any time. Any Participating District reserves the right to withdraw from and terminate its participation in the Program or Plan, thereby terminating, suspending, amending or modifying the Program as to its Program participants. Generally, unless specifically provided otherwise in an underlying document relating to the applicable Plan, any amounts remaining in the Program at termination will be distributed as if they were insurance company refunds/rebates (see heading "Insurance Company Refund").

[Contract Administrator's Right to Interpret the Program](#)

Schools Risk and Insurance Management Group has discretion to interpret the provisions of the Program and any Plan, to make factual determinations, and to delegate such authority. The Contract Administrator's and/or delegate's interpretations and decisions are conclusive and binding on all Program participants.

[Contract Administrator's Right of Reimbursement](#)

To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Program, the following provisions will control as to any Plan.

The Program does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the

action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Program (including, but not limited to, medical benefits under an automobile insurance policy). If an employee, spouse, or dependent (a "Covered Individual") incurs expenses and receives benefits from the Program or its carrier(s) as a result of an injury or accident caused by the action of a third party, immediately upon payment of any benefits under the Program, the Program will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Program.

As a condition to participation in or the receipt of benefits under the Program, a Covered Individual agrees that if such person receives or is entitled to any reimbursement or any other financial recovery from any source, including such Covered Individual's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by an employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury or illness, the Program has the right to recover the amounts the Program has paid or will pay as a result of that injury, from any amounts a Covered Individual received from any party, and the Program has a lien on any such recovery. Similarly, if any person, including any natural person or entity, other than a Covered Individual has possession of funds recovered from a third party as to which any Covered Individuals has or had a claim, then the Program will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. By participating in and accepting benefits under the Program

in connection with such an injury or illness, a Covered Individual agrees and is bound to assist the Program in its attempt to recover from that person, assigns any recovery to the Program and authorizes such Covered Individual's attorney, personal representative, or insurance company to reimburse the Program. In the event that a Covered Individual is deceased, the Program has a right to recover funds from such Covered Individual's estate pursuant to this reimbursement provision. The Program will not pay attorney fees or costs associated with any Covered Individual's claims without prior express written authorization by the Program, which the Program may grant or withhold in its sole discretion. In this regard, the Program will not be subject to any "make whole" or other subrogation rule that may otherwise apply by law that reduces its right to recover the full amount of its loss unless the Program has expressly agreed to do so in writing. Rather, the Program is entitled to full reimbursement:

- (a) before the Covered Individual is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual has other costs or suffered other injuries not paid for or compensated by the Program (notwithstanding any "Make Whole Doctrine");
- (b) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;
- (c) without reduction for attorneys' fees and other costs incurred by the Covered Individual in making a recovery without the prior express written consent of the Program (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine"); and

(d) notwithstanding that the recovery to which the Program is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.

A Covered Individual, and individuals acting on a Covered Individual's behalf, including attorneys, will do nothing to prejudice the Program's subrogation and reimbursement rights and will, when requested, provide the Program with information and cooperate with the Program in the enforcement of its subrogation and reimbursement rights. It is your duty, and the duty of individuals acting on your behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when you give notice to any other party, including an attorney, of your intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Program on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

- (a) informing the Plan Administrator of the action to be taken by the Covered Individual;
- (b) agreeing (in such form and to such documents as the Program may require) to the Program being reimbursed from any recovery from a third party and subrogated to any right of recovery the Covered Individual has against a third party;
- (c) refraining from action which would prejudice the Program's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Program); and

(d) cooperating in doing what is reasonably necessary to assist the Program in any recovery.

If the Covered Individual should fail or refuse to comply with these subrogation and right of reimbursement provisions, the Covered Individual is not entitled to benefits under the Program and must reimburse the Program for any and all costs and expenses, including attorneys' fees, incurred by the Program in enforcing its rights hereunder. The Program may determine not to exercise all of the reimbursement and/or subrogation rights described here in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

For purposes of this section, "reimbursement" includes all direct and indirect payments to a Covered Individual for injury or illness from any source, by way of settlement, judgment, or any other means, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

[Union Agreement's Limits to Contract Administrator's Rights](#)

This Program is subject to collective bargaining agreement(s) with the following union(s): Auburn Union School District (Certificated & Classified), 255 Epperle Lane, Auburn, CA 95603; CTA, 950 Tharp Road, Suite 901, Yuba City, CA 95993; Clear Creek Certificated Bargaining Unit, 17700 McCourtney Road, Grass Valley, CA 95945; Association of Colfax Educators (ACE), Certificated Teacher, 24825 Ben Taylor Road, Colfax, CA 95713; CTA Membership Accounting, P.O. Box 4178, Burlingame, CA 94011-4178; California School Employees Association, 2045 Lundy Avenue, San Jose,

CA 95131; California Teachers Association, P.O. Box 921, Burlingame, CA 94011-0921; California Teachers Association (CTA), P.O. Box 45529, San Francisco, CA 94145-0529; Amalgamated Transit Union, Local 256, 2776 21st Avenue, Sacramento, CA 95841; EUTA - Eureka Union Teacher's Association (CTA/NEA), P.O. Box 4178, Burlingame, CA 94011-4178; EUCO - Eureka Union Classified Organization, 5455 Eureka Road, Granite Bay, CA 95746; California School Employees Association (CSEA), 8217 Auburn Boulevard, Citrus Heights, CA 95610-0310; Nevada Joint Union High School Teachers Association, 11645 Ridge Road, Grass Valley, CA 9595; California School Employees Association, Chapter 165, 11645 Ridge Road, Grass Valley, CA 95945; Placer/Nevada Teachers Union AFT, Local 2267, AFL-CIO, 11645 Ridge Road, Grass Valley, CA 95945; CTA, 8951 Valley View Drive, Newcastle, CA 95658; CSEA, 8951 Valley View Drive, Newcastle, CA 95658; PACE/CTA, 41 Truxel Road, Sacramento, CA 95834; Certificated Union, P.O. Box 255, Weimar, CA 95736; Classified Union, 16505 Placer Hills Road, Meadow Vista, CA 95722; CSEA, P.O. Box 1764, Colfax, CA 95713; Roseville Secondary Association (RSEA), 1750 Cirby Way, Roseville, CA 95661; Union Hill Teacher Association (UHTA), 11638 Colfax Highway, Grass Valley, CA 95945; CTA/WPTA Certificated, P.O. Box 921, Burlingame, CA 94011 (the "Union Agreement"). The applicable Union Agreement may have restrictions relating to the Employer's rights. Union members have certain rights under their Union Agreement, and the Employer cannot make changes to the Program that conflict with that Union Agreement's terms.

Other Continuation / Conversion Privileges

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the State to which your coverage applies (for example, California, New York, or Georgia) for certain insured benefits. The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you must inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Program.

Also, when you are no longer eligible under the Program (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Program.

EMPLOYEE Rights

You are entitled to certain rights and protections including:

- Examine, without charge, at the Plan Administrator's office and at other

specified locations, such as worksites and union halls, all documents governing the Program, including any applicable insurance contracts and collective bargaining agreements, if any.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Program, including any applicable insurance contracts, and collective bargaining agreements, if any
- Continue health care coverage for yourself or your dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Program Description and the documents governing the group health plans for the rules governing your COBRA continuation coverage rights.

No one, including your Employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits under the Program.

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

If you have any questions about your benefits or the Program, you should contact the Plan Administrator.

Appendix A: Plans

The information below is effective July 1, 2020, unless otherwise indicated below.

Plans Offered Under the Program

Attached is a list of each Plan and the eligibility and participation requirements of those plans. Also listed is the name of the individual insurance company that provides benefits (if any) and reviews claims relating to its insurance policy. Also in the attached may be a list of the name of the TPA (if any) that reviews claims made under a Plan.

Generally, unless otherwise indicated in the attached or as provided in **Appendix B**, an

eligible employee under the Program is any regular common-law employee of the Employer who is not a leased employee, contract worker or independent contractor, seasonal employee, variable hour employee, or former employee, and such regular common-law employee is eligible to participate in and receive benefits under one or more of the Plans. Non-resident aliens are also not eligible unless specifically included under “Eligible Employees” below. To determine whether you are eligible to participate in a Plan, please read the eligibility information in the attached for the applicable Plan.

Appendix B: Look-Back Provisions

Look-Back Provisions

The Affordable Care Act (“ACA”) expands opportunities for certain Employees of Applicable Large Employers to participate in health plans. Your Employer believes it is an Applicable Large Employer under the ACA and has elected to take advantage of the look-back provisions of the ACA. In essence, since it may be difficult to determine in advance whether certain traditionally non full-time Employees may work an average of 30 or more hours over an extended period of time, the Employer has elected to adopt a look-back measurement method permitted by law to determine such status and to provide such Employees with future health plan coverage if they meet the 30-hour requirement.

This Look-Back Measurement Method will also apply to Employees hired with the expectation of working full-time, but only once they have been employed through one Standard Measurement Period. Generally, to take advantage of the look-back safe harbor rules, Employees hired with the expectation of working full-time must be offered coverage by no later than the first day of the month immediately following the Employee’s initial three full calendar months of employment. See **Appendix A** for when participation begins if you were hired with the expectation of working as a Full-Time Employee.

Example:

For “New” variable hour and seasonal Employees

Our Organization uses a 12-month Initial Measurement Period that begins on the first of the month coinciding with or

following the start date and ends on the last day of the 12th month of employment. It applies an Initial Administrative Period from the end of the Initial Measurement Period through the end of the first calendar month beginning on or after the end of the Initial Measurement Period. For example, Our Organization hires Workmore Jones on July 10, 2018 to work a “part-time” schedule of 25 hours per week; however, Workmore ends up working much more. Workmore’s Initial Measurement Period runs from August 1, 2018 through July 31, 2019. The Initial Administrative Period is from August 1, 2019 through August 31, 2019. During the Initial Administrative Period, Our Organization determined that Workmore worked an average of 30 hours per week. Therefore, Our Organization must offer coverage to Workmore during the Initial Stability Period, which runs from September 1, 2019 through August 31, 2020.

For “Ongoing” Employees (who have worked through a full Standard Measurement Period)

Our Organization uses a 12-month Standard Measurement Period that begins May 1, 2019 and ends on April 30, 2020, and it will begin on May 1 and end on April 30 of each succeeding year thereafter. Our Organization applies a Standard Administrative Period that begins on May 1, 2020 and ends on June 30, 2020, and it begins on May 1 and ends on June 30 of each succeeding year thereafter. During the Standard Administrative Period, Our Organization determined that Workmore worked an average of 30 hours per week during the Standard Measurement Period. Therefore, Our Organization must offer coverage to Workmore during the Standard Stability Period, which runs from July 1, 2020 through June 30, 2021, and runs from July 1 through June 30 of each succeeding year thereafter.

Workmore's Date of Hire:	July 10, 2018
Initial Administrative Period (Begin Split):	July 10, 2018 - July 31, 2018
Initial Measurement Period Begins:	August 1, 2018
Standard Measurement Period Begins*:	May 1, 2019
Initial Measurement Period Ends:	July 31, 2019
Initial Administrative Period (End Split):	August 1, 2019 - August 31, 2019
Initial Stability Period Begins:	September 1, 2019
Standard Measurement Period Ends*:	April 30, 2020
Workmore becomes Ongoing*:	May 1, 2020
Standard Administrative Period*:	May 1, 2020 – June 30, 2020
Standard Stability Period Begins*:	July 1, 2020
Initial Stability Period Ends:	August 31, 2020
Standard Stability Period Ends*:	June 30, 2021

***Reflects that Standard Measurement, Administrative and Stability Periods overlap
Initial Measurement, Administrative and Stability Periods.**