Consumer Driven Health Plan

Effective: July 1, 2005
Restated: July 1, 2018

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by (the "Company" or the "Plan Sponsor") as of July 01, 2018, hereby sets forth the provisions of the Tri-County Schools Insurance Group Consumer Driven Health Care Plan (the "Plan"), which was originally adopted by the Company, effective July 1, 2005. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required. This Plan is intended to meet all Internal Revenue Service (IRS) regulations of a Health Savings Account (HSA)-qualified "High Deductible Health Plan" (HDHP).

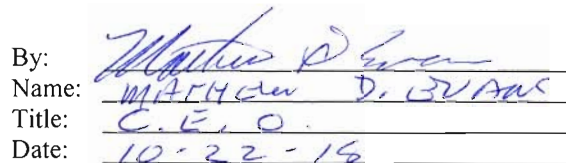
Effective Date

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

Adoption of the Plan Document

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

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



By:
Name:
Title:
Date:

PREFACE

Tri-County Schools Insurance Group (TCSIG) has been established to provide benefit programs for its participating Employers' eligible Employees and their eligible Dependents. TCSIG creates and establishes the Consumer Driven Health Plan, hereinafter referred to as the "Plan" and this document thereinafter referred to as the "Plan Document."

The purpose of this Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement for all or a portion of covered medical expenses.

TCSIG assures the eligible Employees, that during the continuance of the Plan, all benefits hereinafter discussed shall be paid to them in the event that they and/or their eligible Dependent(s) incur allowable medical expenses. The Plan is subject to all terms, provisions and conditions recited on the following pages.

This Plan Document shall be the sole document used in determining benefits to which Covered Persons are eligible and may be amended from time to time with proper advance notification by TCSIG. Any change so made shall be binding on each individual covered and on any other individual or individuals referred to in this Plan Document.

Wherever used in this Plan Document, masculine pronouns shall include both masculine and feminine genders unless the context indicates otherwise.

The self-funded benefits offered by the Plan do not constitute the act of insurance. The self-funded benefits are not guaranteed and may be amended or withdrawn at any time by TCSIG or the Employer, without the consent of any Covered Person or any other party, as long as prior notification is provided by TCSIG.

It is the objective of the medical plans to be in compliance with the Patient Protection and Affordable Care Act provisions for essential benefits as defined by the Health and Human Services Department (HHS). In any case where the plan provisions are found to be inconsistent with HHS guidance, the Plan Administrator will adjust the benefit determination to bring the plan into compliance. Such adjustment shall not negate other provisions of the plan document.

TCSIG has caused this Plan Document to take effect as of the first day of July 2018, at Yuba City, California.

TRI-COUNTY SCHOOLS INSURANCE GROUP

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PLAN INFORMATION

Name of Plan:

Tri-County Schools Insurance Group (TCSIG) Consumer Driven Health Plan
EIN: 68-0279058

Plan Administrator/Agent for Service of Legal Process:

Tri-County Schools Insurance Group (TCSIG)
1176 Live Oak Boulevard, Suite A
Yuba City, CA 95991
(530) 822-5299
(866) 822-5299
Benefit Plan Year January 1st - December 31st
Policy Plan Year July 1st - June 30th

Type of Plan:

Self-insured Employee Welfare Benefit Plan: medical, prescription Drug, and mental health.

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the Plan are provided through a company contracted by TCSIG and shall hereinafter be referred to as the Claims Administrator. The designated Claims Administrator is:

Delta Health Systems
3244 Brookside Road
P. O. Box 80
Stockton, CA 95201
(800) 422-6099
(800) 464-7627 Claims Department/Customer Service

Applicable Law:

This Plan is not a plan of insurance. This Plan is a self-funded governmental group health plan which, for the most part, is exempt from the requirements of ERISA (the Employee Retirement Income Security Act).

However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed, and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Mental Health Parity Opt-Out

Tri-County Schools Insurance Group (TCSIG) has elected to exempt **Consumer Driven Health Plan** from parity in the application of certain limits to mental health benefits and to allow first dollar benefits for outpatient services without having a Deductible requirement.

Tri-County Schools Insurance Group already provides significant mental health benefits which are reviewed annually and adjusted as necessary to meet the needs of our members. Changing outpatient benefits and requiring a Deductible or payment of a Coinsurance percentage would in many cases be a barrier to receiving needed care. Outpatient and Inpatient limits may be subject to case management/alternative treatment review on a case-by-case basis.

PLAN HIGHLIGHTS

This section is provided as an overview of the key provisions of the Plan. For complete details, refer to specified sections of the Plan.

Definitions:

This document contains terms that have specific meaning with regard to the intent of this Plan. (See Definitions) All such terms with the first letter capitalized are defined.

Eligibility and Effective Date of Coverage:

TCSIG deems all Employee Groups to be eligible to participate in the Plan. However, it is at the discretion of each Employer to determine which Employee Groups shall be eligible to participate in this Plan. Coverage for eligible Employee Groups shall begin as determined by the written policies of the Employer but no sooner than the first of the month following the date of employment.

As specified in the Eligibility section of this Plan, family members are eligible for Dependent coverage under the Plan, and their coverage will usually begin at the same time as the Employee's coverage. (See Eligibility, Application for Enrollment and Effective Date of Coverage.)

Cost of Coverage:

The participating Employers shall maintain discretion as to whether or not an Employee Group shall contribute toward the cost of coverage under this Plan. The same rate structure, i.e., composite or tiered, shall apply for all active Employees in a group. Retirees shall be placed on the tiered rate structure or may be placed, with their Employer's approval, on a composite rate if they enroll two or more Dependents and their former, active group is also composite. If a Retiree enrolls in both Medicare Parts A and B, TCSIG may provide a reduced contribution schedule, provided the Plan is secondary payer to Medicare. Individuals who continue their coverage under the Continuation of Coverage provision may be required to pay the entire cost of that coverage, plus an additional fee as allowed by Federal law.

Benefits Provided:

The Plan provides medical and prescription Drug benefits for participating Employers' eligible Employees and their Dependents. For medical benefits, Covered Persons have the choice of using either a Preferred Provider or a Non-Preferred Provider. Benefits are usually greater when utilizing the services of a Preferred Provider than those available when using the services of a Non-Preferred Provider. TCSIG has contracted with PPO Networks in order to provide the best services at the best rate to Covered Persons. The Networks are divided into the following categories: medical, prescriptions, managed mental health care/Chemical Dependency and chiropractic. It is the responsibility of the Covered Person to assure services to be rendered are performed by Preferred Provider Physicians, Practitioners, facilities and other ancillary services in order to receive the Preferred Provider level of benefits. Referrals to a Non-Preferred Provider are covered as Non-Preferred Provider services and supplies except as otherwise provided.

Before the Plan will pay on any Preferred Provider medical claim, the Covered Person must have paid from "his own pocket" the PPO "Deductible" of Covered Expenses for the Calendar Year. The PPO Family Deductible requirement shall also be satisfied for every Covered Person in the family when the total PPO Deductible payments for the family have been made for the Calendar Year.

After the PPO Deductible has been satisfied, the Plan will usually pay the appropriate PPO Benefit Percentage until the maximum Out-of-Pocket expense has been met. Thereafter, the Plan shall pay one hundred percent (100%) for the remainder of the Calendar Year except as otherwise indicated. Percentages represent the Plan's payment of the Negotiated Rate for Covered Expenses. Certain benefits are limited; refer to the Schedule of Benefits and Medical Expense Benefit for more information.

Before the Plan will pay on any Non-Preferred Provider medical claim, the Covered Person must have paid from "his own pocket" the Non-PPO "Deductible" of Covered Expenses for the Calendar Year. The Non-PPO Deductible requirement shall also be satisfied for every Covered Person in the family when the total of Non-PPO Deductible payments for the family has been made for the Calendar Year. After the Non-PPO Deductible has been satisfied, the Plan will usually pay the Non-PPO Benefit Percentage of Covered Expenses incurred during the Calendar Year for the Covered Person until the maximum Out-of-Pocket has been met. Thereafter, the Plan shall pay one hundred percent (100%) for the remainder of the Calendar Year except as otherwise indicated.

Percentages represent the Plan's payment of Reasonable and Allowed Amounts for Covered Expenses. Certain benefits are limited; refer to the Schedule of Benefits and Medical Expense Benefit for more information.

Pre-Certification:

The Plan requires Pre-certification for the following:

- Hospitalization-Inpatient
- Hospice Care
- Skilled Nursing Facility
- Home Health Care
- Home Infusion Therapy
- Surgery and Anesthesiology
- Organ or Tissue Transplants
- Durable Medical Equipment over $2,000
- Chiropractic Care after 12 visits and for Children under the age of 18.
- Temporomandibular Joint Syndrome (TMJ)
- Mental Health Disorders/Chemical Dependency for Inpatient, Outpatient Services
- Pregnancy*

The Utilization Review Organization (URO) must be notified and provided certain information on any of the above procedures or services. If the hospitalization is planned in advance, the call must be made prior to admission. If it is an Emergency Admission, the call must be made within forty-eight (48) hours of admission, or the next business day.

*Pre-certification is required for Hospital services in excess of forty-eight (48) hours for a normal vaginal delivery and ninety-six (96) hours for a cesarean section.

All treatment, Inpatient and Outpatient, for Mental Health Disorders and Chemical Dependency must be Pre-certified by the managed psychiatric health care and Chemical Dependency services Network. For Emergency Admission, the Covered Person or their designated representative must obtain certification within seventy-two (72) hours.

If the required Pre-certification is not obtained, the benefits payable shall be reduced by fifty percent (50%). (See Cost Containment.)

Exclusions:

There are expenses that are not covered by the Plan. A general listing of services and items excluded from the Plan can be found in Plan Exclusions.

Filing Claims:

Claims must be submitted to the Claims Administrator within ninety (90) days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as reasonably possible. The Provider of service may submit claims to the Claims Administrator on behalf of the Employee or their Dependents. However, the Employee is ultimately responsible to ensure claims are submitted in a timely manner. To obtain reimbursement for Covered Expenses that have already been paid by the Covered Person, an itemized bill and claim form must be submitted to the Claims Administrator. (See Claim Procedure and Payment of Benefits.)

Continuation of Coverage:

If coverage under the Plan ceases for certain reasons, coverage may be continued at the Covered Person's expense, in accordance with the Public Health Services Act. Dependents covered by the Plan are also entitled to continuation of coverage under certain circumstances. (See Continuation of Coverage.)

Coordination of Benefits:

This Plan is designed to help the Covered Person meet the cost of Illness or Injury. It shall not provide benefits greater than actual expenses. Therefore, the Plan shall take into account and coordinate with the benefits of any Other Plan which provides medical benefits so that the combined benefits of the plans do not exceed one hundred percent (100%) of the allowable Covered Expenses incurred during the Claim Determination Period. The benefits paid under this Plan shall not exceed those which would be payable in the absence of any Other Plan.

When more than one coverage exists, the primary plan is required to pay its benefits first, then the secondary plan may pay a reduced benefit. If this Plan is secondary, the primary coverage must be used first. If the Covered Person does not abide by the primary plan's guidelines for Pre-certification and contracted Providers, this Plan will exclude the expenses incurred for any penalty and/or reduction of benefits incurred for the failure to obtain Pre-certification, or for non-participating services.

Subrogation/Third Party Liability Reimbursement:

As a condition of receiving benefits under the Plan, the Covered Person agrees to the Plan's right to reimbursement of benefits paid on behalf of the Covered Person for expenses incurred due to the actions or inactions of a third party. (Refer to Subrogation/Third Party Liability Reimbursement.)

Benefit Plan Year/Policy Plan Year:

The Calendar Year and tax year coincides with the **BENEFIT PLAN YEAR** which begins January 1st and goes through the following December 31st. The **BENEFIT PLAN YEAR** is used for calculation of Deductibles, Coinsurance, day or visit limitations and related aspects of a self-only or a family benefit.

The fiscal year for local governmental public agencies coincides with the POLICY PLAN YEAR which begins July 1st and goes through the following June 30th. The POLICY PLAN YEAR is the normal Effective Date of Open Enrollment plan changes. The POLICY PLAN YEAR is used for placement of STOP LOSS coverage above self-insured retention.

SCHEDULE OF DEDUCTIBLES AND COINSURANCES

Benefits	Self Only	Employee + 1 or Family
Maximum Lifetime	There are no lifetime limits	

Calendar Year Deductible

PPO Self-only PPO Family	$1,500	$3,000
Non-PPO Self-only and Family	$3,000	$6,000

Coinsurance

PPO Self-only and PPO Family	50%	50%
Non-PPO Self-only and Family	60%	60%

Calendar Year Maximum Medical and Prescription PPO Out-of-Pocket

Includes PPO Deductibles and Coinsurances from medical, chiropractic, out-patient mental health.		
PPO Self-only	$5,000	$10,000
PPO Family	$10,000	$20,000

Plan pays one hundred percent (100%) of allowable medically necessary charges at PPO Provider discount or Reasonable and Allowable Amount for Non-PPO Provider except required, after self-only or Family Deductible and Coinsurance has been met. Chiropractic charges are paid by a PPO network fee schedule; chiropractic non-network allowed amounts are one half the network fee schedule.

	CDHP Self Only	CDHP Employee + 1 or Family
Lifetime Maximum	NO LIFETIME LIMTS	
Calendar Year Deductible	Subject to Internal Revenue Code and may be adjusted annually, January 1st.	
Calendar Year Coinsurance	After Deductible the Plan Pays 50% In-Network and 40% Out-of-Network	
Maximum Out-of-Pocket	Subject to Internal Revenue Code and may be adjusted annually, January 1st.	

SCHEDULE OF BENEFITS

The following Schedule of Benefits is designed as a reference. Percentages represent Plan payment of the Negotiated Rate for Preferred Providers, and Reasonable and Allowed Amount for Non-Preferred Providers. **Covered Services will be subject to the appropriate Deductible and Coinsurance.**

Benefit	Covered Services	Pre-Certification
Ambulance Page 33	Medical necessity to and from a Hospital	No
Assistant Surgeon	No greater than 20% of the primary surgeon's Covered Expenses.	No
Bereavement Counseling Page 38	Maximum Benefit is $25 per visit to a Maximum of four visits	No
Birthing Center Page 35	Services and supplies rendered at a Birthing Center, as defined.	No
Chiropractic Care	Maximum visit is one visit per day.	Yes after 12 visits and for children under the age of 18.
Diagnostic X-Ray & Lab Page 36	Covered Expenses shall include services and supplies for diagnostic services.	No
Durable Medical Equipment Page 39	Rental or purchase, whichever is less costly of necessary Durable Medical Equipment that is prescribed by a Physician and required for therapeutic use by the Covered Person.	Yes
Habilitative Services Page 43	Maximum Benefit is 20 visits per Calendar Year	No
Home Health Care Page 37	Medically necessary skilled care, not Custodial Care, furnished by a Home Health Agency or visiting Nurse association, up to 100 visits per Calendar Year.	Yes
Hospice Care Page 38	Subject to Deductible and Coinsurance.	Yes
Hospital – Inpatient Page 32	Room and board, medically necessary accommodations and miscellaneous Hospital services, supplies and treatment.	Yes
Hospital Emergency Room Page 33	Subject to a Deductible and Coinsurance	No
Immunizations Page 39	As Preventive Care for Children, adolescence and adults subject to the Center for Disease Control (CDC) recommendations. **Does not include immunizations for foreign travel.**	No

Benefit	Covered Services	Pre-Certification
Mental Health / Chemical Dependency Page 42	In-patient Hospitalization, Residential Treatment and Day Treatment Centers: Maximum Benefit for Mental Health and Chemical Dependency is 30 days per Calendar Year and 90 days while covered by this Plan. Subject to Deductible and Coinsurance. **Non-PPO Providers are NOT Covered** Out-patient: PPO Provider Maximum amount allowed is $100 subject to Deductible and Coinsurance. One visit per day, Maximum Benefit for In-patient and Outpatient is 52 visits per Calendar Year. Non-PPO Provider Maximum amount allowed is $50 subject to Deductible and Coinsurance. One visit per day, 52 visits per Calendar Year	Yes
Newborn Services Page 35	Covered Expenses for a well newborn Child incurred for Hospital services to include routine nursery charges, initial Physician examination and circumcision, while the mother is confined for delivery shall be added to Covered Expenses of the mother to determine allowable benefits payable (one Deductible) provided the natural mother is enrolled under the Plan.	No
Outpatient Surgery Page 32	Ambulatory Surgical Centers Hospital based Outpatient Surgical Centers	No
Physical /Occupational Therapy Page 40	Maximum Benefit is one treatment per day.	No
Physician/Practitioner Services Page 34	Subject to Deductible and Coinsurance for Office Visits as listed in the Schedule of Coinsurance and Deductibles.	No
Pre-Admission Testing Page 33	Pre-Admission Testing for Medically Necessary tests shall be covered. Subject to Deductible and Coinsurance.	No
Pregnancy Page 35	Certification is required for Hospital services in excess of forty-eight (48) hours for a normal vaginal delivery and ninety-six (96) hours for a cesarean section.	No

Benefit	Covered Services	Pre-Certification
Prescription Drugs Pages 42-43	**31-Day supply:** Patient pays 100% at the point of sale. Reimbursed 50% after satisfying the Deductible and 100% after satisfying the Coinsurance. Limitation: Not to exceed a thirty-one (31) day supply of generic/formulary when available. **90-Day supply**: Patient pays 100% at the point of sale. Reimbursed 50% after satisfying the Deductible and 100% after satisfying the Coinsurance. Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be responsible for the difference, in cost, between the brand name and the generic. **Limitation**: Not to exceed a ninety (90) day supply of generic/formulary when available **90-Day supply:** Patient pays 100% at the point of sale. Reimbursed 50% after satisfying the Deductible and 100% after satisfying the Coinsurance. Limitation: Not to exceed a ninety (90) day supply of generic/formulary when available. Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be responsible for the difference, in cost, between the brand name and the generic. Patient pays 100% of the contracted rate at the point of sale. Reimbursed after applying Deductible and Coinsurance.	Requires the use of a Network Pharmacy or there is NO benefit. List of contracting Network Pharmacies available at www.tcsig.com Requires the use of the contracted Mail Order company or there is NO benefit. If the Covered Person does not use the services of a Network Pharmacy, or if the service is not processed through the Network, the Covered Person is responsible for the applicable Coinsurance plus the difference in cost between the contract rate and the invoiced rate.
Preventive Care Services and Wellness Examination Including routine Laboratory Page 39	One routine physical examination/visit per Calendar Year for Employee, covered spouse and eligible Dependents as recommended by U.S. Preventive Services Task Force grade of A or B. Payable in-Network at 100% of contract rate; non-Network subject to Non-PPO Deductible and Coinsurance based on Reasonable and Allowed Amount.	No

Benefit	Covered Services	Pre-Certification
Skilled Nursing Facility Page 36	Medically necessary skilled care, not custodial care, in a Skilled Nursing Facility, up to 100 days per calendar year.	Yes
Speech Therapy Page 40	Covered if ordered by a physician to aid restoration due to Illness or Injury. Limitations and Exclusions apply.	No
Surgery and Anesthesiology – Inpatient Page 32	Covered subject to Deductible and Coinsurance.	Yes
Temporomandibular Joint Syndrome (TMJ) Page 40	Subject to Deductible and Coinsurance	Yes
Transplants Page 34	Room and board, medically necessary accommodations and miscellaneous Hospital services, supplies and treatment.	Yes

Pre-certification is required as listed on the above services. The benefits payable shall be reduced by fifty percent (50%) if Pre-certification is not obtained from the Utilization Review Organization (URO). Refer to Cost Containment for more information.

TCSIG has contracted with a pharmaceutical Network to provide prescription drugs and medicines. The dispensing limitation is the amount normally prescribed by a Physician, but not to exceed a thirty-one (31) day supply. TCSIG has also contracted with a company to provide maintenance drugs at a discounted rate through a mail order program. If the Covered Person requires a maintenance type drug, the Physician may write the prescription for up to a ninety (90) day supply.

COST CONTAINMENT

Cost containment is a means of monitoring services for medical necessity to help ensure cost-effective care. Properly administered, cost containment can eliminate unnecessary services, hospitalizations, and shorten Confinements, while improving quality of care and reducing costs to the Covered Person and the Plan. Cost containment as administered by the Utilization Review Organization (URO) includes Pre-certification and managed care.

Certification of medical necessity by the Utilization Review Organization (URO) does not establish eligibility under the Plan nor guarantee benefits. Charges not deemed to be medically necessary by the Utilization Review Organization (URO) shall be denied.

PRE-CERTIFICATION

Hospital/Surgery/Hospice:

All Hospital admissions and Hospice care MUST be certified IN ADVANCE (Pre-certification) by the Utilization Review Organization (URO), except for emergencies. The Covered Person or their designated representative should call the Utilization Review Organization (URO) at least three (3) days prior to admission.

Emergency Hospital admissions MUST be reported to the Utilization Review Organization (URO) within forty-eight (48) hours following admission or Surgery, or on the next business day.

The benefits payable for covered facility charges for Hospital Confinement shall be reduced by fifty percent (50%) if Pre-certification is not obtained. The benefits payable for Hospice care and all related Hospice charges shall be reduced by fifty percent (50%) if Pre-certification is not obtained.

After admission to the Hospital, the Utilization Review Organization (URO) will continue to evaluate the Covered Person's progress through Concurrent Review to monitor the length of Confinement. If the Utilization Review Organization (URO) disagrees with the length of Confinement recommended by the Physician, the Covered Person and the Physician will be advised. If the Utilization Review Organization (URO) determines that continued Confinement is no longer necessary, additional days will not be certified.

Phase I, II, III, or IV Clinical Trials:

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

a. The clinical trial is approved by:

    i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;

    ii. The National Institute of Health;

    iii. The U.S. Food and Drug Administration;

    iv. The U.S. Department of Defense;

    v. The U.S. Department of Veterans Affairs; or

    vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

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

Coverage will not be provided for:

a. The cost of an Investigational new Drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a Drug or device that is the subject of the Approved Clinical Trial;

b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;

c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;

d. A cost associated with managing an Approved Clinical Trial;

e. The cost of a health care service that is specifically excluded by the Plan; or

f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

“Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services (“CMS”), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

Transplants:

Pre-certification by the Utilization Review Organization (URO) is required for all transplants. The Covered Person or their designated representative should call the Utilization Review Organization (URO). **Benefits payable shall be reduced by fifty percent (50%) if Pre-certification is not obtained.**

Skilled Nursing Facility/Home Health Care/Home Infusion Services:

Pre-certification by the Utilization Review Organization (URO) is required for Skilled Nursing Facility, Home Health Care and Home Infusion Services. The Covered Person or their designated representative should call the Utilization Review Organization (URO) at least three (3) business days prior to the Confinement or service. **Benefits payable shall be reduced by fifty percent (50%) if Pre-certification is not obtained.**

Mental Health Disorders/Chemical Dependency:

Pre-certification by the managed psychiatric health care and Chemical Dependency services Network is required for all treatment, Inpatient and Outpatient, for Mental Health Disorders and Chemical Dependency to be eligible for full Plan benefits. However, in the case of an Emergency Admission, the Covered Person or their designated representative must obtain certification within seventy-two (72) hours following admission or initial Outpatient treatment. **The benefits payable shall be reduced by fifty percent (50%) if Pre-certification is not obtained.**

Pregnancy:

Certification is required for Hospital services in excess of forty-eight (48) hours for a normal vaginal delivery and ninety-six (96) hours for a cesarean section.

Durable Medical Equipment:

Pre-certification is required for Durable Medical Equipment over $2,000. Prior to ordering the Durable Medical Equipment the Covered Person or their designated representative should call the Utilization Review Organization (URO). **Benefits payable shall be reduced by fifty percent (50%) if Pre-certification is not obtained.**

PRE-CERTIFICATION APPEAL PROCESS

In the event certification is denied by the Utilization Review Organization (URO), the Covered Person or Provider of service may submit an appeal to the Utilization Review Organization (URO). The Covered Person may call the Utilization Review Organization (URO) or TCSIG for more information concerning the appeal process.

The managed psychiatric health care and Chemical Dependency Network (Network) provides Covered Persons with a separate appeal process. Either the Covered Person or the Provider of service may submit an appeal to the Network. The Covered Person may call the Network or TCSIG for more information concerning the appeal process. (Also see Adverse Benefit Decisions: Right to Appeal, page 53.)

CASE MANAGEMENT/ALTERNATE TREATMENT

TCSIG may arrange for review and/or case management services from a professional organization qualified to perform such services. Case management may apply to both Inpatient and Outpatient. The TCSIG Executive Committee or its designated representative shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result while maintaining the quality of care.

Benefits provided under this section are subject to all other Plan provisions. Alternative care shall be determined on the merits of each individual case, and any care or treatment provided shall not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

PREFERRED PROVIDER OR NON-PREFERRED PROVIDER

Covered Persons have the choice of using either a Preferred Provider or a Non-Preferred Provider. A Preferred Provider is a Physician, Practitioner, Hospital or ancillary service which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a Negotiated Rate as payment in full. A Non-Preferred Provider does not have an agreement in effect with the Preferred Provider Organization (PPO).

PPO – Preferred Providers:

Because the Covered Person and the Plan save money when services or supplies are obtained from a Provider participating in the Preferred Provider Organization (PPO), benefits are usually greater than those available when using the services of a Non-Preferred Provider. TCSIG has contracted with four (4) separate PPO Networks in order to provide the best services at the best rate to Covered Persons. The Networks are divided into the following categories:

Medical
Prescription Drugs and Medications
Managed psychiatric health care and Chemical Dependency
Chiropractic Network

When choosing a Preferred Provider Hospital to schedule medical treatment that will require the services of ancillary Providers, **confirmation of the contract status for these Providers is advised and is the sole responsibility of the Covered Person.** As Hospitals periodically "contract out" for ancillary services, these Providers may not be employed by the Hospital and, therefore, would not be obligated to accept the Negotiated Rate. The Covered Person may be responsible for additional charges incurred by utilizing a Non-Preferred Provider.

Non-PPO - Non-Preferred Providers:

This Plan does not limit the choice of a health care Provider, such as a Physician or Hospital, as long as the Provider is qualified in accordance with the terms defined in this Plan. However, the Covered Person may have more Out-of-pocket expense by using Non-Preferred Provider services.

Inpatient Mental Health Services: If services and supplies for the treatment of Inpatient, residential Treatment Centers or day treatment for Mental Health Disorders/Chemical Dependency are rendered by a Non-Network Provider, NO benefit is payable.

Outpatient Mental Health Services: If services and supplies for the treatment of Mental Disorders/Chemical Dependency are rendered by a Non-Network Provider, the Non-Network Provider must be certified by the Network, and comply with the Network's managed care guidelines and procedures.

Referrals:

Referrals to Non-Preferred Providers are covered as Non-Preferred Provider services and supplies. It is the responsibility of the Covered Person to assure services to be rendered are performed by a Preferred Provider in order to receive the Preferred Provider level of benefits.

Exceptions:

The following listing of exceptions represents services, supplies or treatments rendered by a Non-PPO facility or Provider where Covered Expenses shall be payable at Reasonable and Allowable Amount after the appropriate PPO Deductible.

1. Emergency treatment rendered at a Non-PPO facility. If the Covered Person is admitted to the Hospital for Emergency treatment, Covered Expenses shall be payable at the PPO Provider level. If the Covered Person receives such initial care from a Non-PPO Provider Hospital, in order to receive full benefits, the Covered Person shall be relocated to a PPO Provider Hospital, as soon as the Covered Person can be safely moved. If the Covered Person does not relocate to a participating Provider Hospital, the Plan's payment shall be in accordance with the Non-PPO Provider level of benefit.

2. Emergency services provided by other than a Hospital.

3. Non-PPO anesthesiologist if the operating surgeon is a PPO Provider.

4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a Non-PPO Provider when the facility rendering such services is a PPO Provider.

5. While confined to a PPO Provider Hospital, the PPO Provider Physician requests a consultation from a Non-PPO Provider.

6. Covered Persons who do not have access to PPO Providers within fifty (50) miles by the shortest route to a PPO Provider from the Covered Person's residence or employment site. If the Covered Person travels to an area that has PPO Providers, the Covered Person must use the PPO Providers to receive the PPO level of benefits. Services for Mental Health Disorders/Chemical Dependency must be pre-certified by the managed psychiatric health care and Chemical Dependency service Network and comply with the Network's managed care guidelines and procedures. This fifty (50) mile provision does not apply to Inpatient, residential Treatment Centers and day Treatment Centers for Mental Health Disorders/Chemical Dependency services.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

TCSIG deems all Employee Groups to be eligible to participate in the Plan provided: (1) the Employee regularly works twenty (20) hours or more per work week or, (2) is a contracted certified (academic) Employee with a fifty percent (50%) or greater full-time equivalent workload. However, it is at the discretion of each Employer to determine which Employee Groups shall be eligible to participate in the Plan.

Subject to the Employer's bargaining agreement(s) or policies, Retired Employees may be eligible to participate in the Plan provided: (1) they are eligible for pension benefits from the Public Employees' Retirement System (P.E.R.S.), the State Teachers' Retirement System (S.T.R.S.), or other recognized public Employee retirement system, and (2) they were covered under a TCSIG Plan on the date immediately prior to retirement. Retired Employees are considered part of the Employee Group they were in just prior to retirement.

Eligibility for active elected officials is at the option of each Employer. Retired elected officials who have completed one or more terms of office shall be eligible for coverage under this Plan provided: (1) the Employer has a policy that allows Retired elected officials to participate as an eligible group, (2) they were covered under a TCSIG Plan on the date immediately prior to retirement, and (3) Retired elected officials are considered part of the Employee Group they were in just prior to retirement. If the Employer elects to provide coverage to active or Retired elected officials, all Plan provisions shall apply.

DEPENDENT(S) ELIGIBILITY

Every eligible Employee may enroll as Dependents his or her spouse and each Child from birth to the Child's twenty-sixth (26th) birthday. The Plan will require proof of Dependent status as specified below within thirty-one (31) days of enrollment and thereafter as requested by TCSIG or the Claims Administrator, but not more than once every two (2) years.

1. The term "spouse" means the spouse or domestic partner of the Employee under a legally valid existing marriage or domestic partnership as determined by the State of California. However, if the Employee and spouse or domestic partners are legally separated, the spouse's or domestic partner's eligibility shall cease.

2. The term "Child" means the Employee's natural Child, step-Child, legally adopted Child and/or ward to the Child's twenty-sixth (26th) birthday. An adopted Child or ward shall be considered a "Child" from the moment the Child is placed in the custody of the parents for adoption or guardianship. Legal evidence of adoption or guardianship of the person (ward) or intent to adopt is required.

3. A Child who has a physical and/or mental disability that existed prior to age twenty-six (26) and continues to the present time shall remain eligible for coverage provided:

A. The Child is unmarried; and

B. The Child is incapable of self-sustaining employment due to mental and/or physical disability; and

C. The Child is principally dependent upon the Employee for support and maintenance. (Named as an exemption on the Employee's most current Federal Income Tax Return. Proof may be required.); and

D. The Dependent must have been covered under the Plan before attaining the limiting age in order to be eligible for continued coverage. A disability is a physical and/or mental impairment that prevents or interferes with normal functions, activities or achievement. Proof of incapacitation must be provided at the Employee's expense within thirty-one (31) days of the Child's twenty-sixth (26) birthday and thereafter as requested by TCSIG or the Claims Administrator, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:

A. Cessation of the disability;

B. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Eligible Dependents do not include:

1. Children of a Dependent Child.

2. Dependents who are, or become, a full-time member of the armed forces of any country.

3. Grandchildren or foster Children, unless legally adopted and/or ward.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An Employee must file a written application with the Employer for coverage hereunder for himself and his eligible Dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage/domestic partnership, or the acquiring of Children or birth of a Child. The Employee shall have the responsibility of timely forwarding to the Employer all applications for enrollment hereunder and any required contribution.

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment Period below, applications for Employee or Dependent coverage which are not filed with the Employer within such **thirty-one (31) days** of meeting the Plan's eligibility requirements shall be subject to this Late Enrollment provision. Employees and/or eligible Dependents who were eligible for coverage but elected not to enroll shall be able to enroll for coverage during the Plan's annual Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An Employee or Dependent who previously declined coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment

period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of Employer contributions toward the other coverage.
3. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
4. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The Employee or Dependent must properly file an application for enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The Effective Date of coverage as the result of a special enrollment shall be the day immediately following the date other coverage terminates.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

This Special Enrollment Period (Dependent Acquisition) allows an eligible Employee including one who has previously waived coverage to enroll when he/she marries, enters a domestic partnership, or acquires a new Child.

The Employee must properly file an application for enrollment and enroll within thirty-one (31) days of the acquisition of the Dependent**.** The Employee may change plans at this time. The Effective Date of coverage as the result of a special enrollment shall be:

1. In the case of marriage/domestic partnership, the date of marriage/domestic partnership;

2. In the case of a Dependent's birth, the date of such birth;

3. In the case of adoption, placement for adoption or guardianship (ward), the date of such adoption, placement for adoption or guardianship occurred.

The monthly contribution for coverage will not be pro-rated for any portion of a month. If coverage for a newly acquired dependent begins before the 16th of the month, the new increased premium will be charged for the entire month. If not, the premium will be increased the first of the following month.

STATUS CHANGE

1. For Employee's who have an employment status change with the Employer coverage will be effective on the first of the month following receipt of written application for enrollment and any required contribution.

2. If an Employee is removed from Active Employment due to total disability, the Employer shall notify TCSIG the same business day of the action.

Upon approval by TCSIG, enrollment changes requested by an Employer under a collective bargaining agreement.

Once enrolled in the Plan, **it is the responsibility of the Employee to notify the Employer** of any change in eligibility of Dependents including the birth of a Child that is to be covered and adding or deleting any other Dependents.

OPEN ENROLLMENT

The annual open enrollment is to allow Employees, Retirees, and their eligible Dependents who are currently enrolled in a TCSIG medical benefits plan the opportunity to enroll in any TCSIG medical plan offered by their Employer. In addition, Employees may enroll their eligible Dependents who are not currently enrolled under a TCSIG plan. Retirees and Retired elected officials and any Dependents of Retirees and Retired elected officials that discontinue coverage cannot re-enroll in this Plan unless they continue to be enrolled as a dependent under their spouse's TCSIG medical plan. The period of the annual open enrollment and the Effective Date of coverage after open enrollment shall be determined by TCSIG. Enrollment is for a period of twelve (12) months subject to the Plan provisions. Participation by individual Employers in the annual open enrollment shall be at the sole discretion of each Employer.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

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

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

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

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

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

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
    a. Be in writing.
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

New Employer Membership

Eligible Employees of a new Employer of TCSIG who are Actively at Work and were covered under the Prior Plan of the new Employer will be eligible for the benefits under this Plan on their effective date with TCSIG. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that a new Employer did not have a health plan, all eligible Employees will be eligible on the date of their effective date with TCSIG.

Genetic Information Nondiscrimination Act ("GINA")

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

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

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

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

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

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

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

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group

contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

CONTRIBUTIONS

The participating Employers shall maintain discretion as to whether or not an Employee Group shall contribute toward the cost of coverage under this Plan. The same rate structure (i.e., composite or tiered) shall apply for all Employees in an Employee Group.

All covered Retirees age sixty-five (65) and older who are eligible for Medicare Part A must enroll in Medicare A and B. If any retired Covered Person is eligible for Medicare Parts A and B and fails to enroll, benefits will be paid as though he had enrolled. If the Employer elects Retirees to be eligible to participate, contributions may be Retiree or Employer paid at the discretion of the Employer. Retirees shall be placed on the tiered rate structure or may be placed, with their Employer's approval, on a composite rate if they enroll two or more dependents and their former, active group is also composite. If a Retiree enrolls in both Medicare Parts A and B, TCSIG may provide a discounted contribution schedule, provided the Plan is secondary payer to Medicare.

EFFECTIVE DATE OF COVERAGE

Employees and Dependents who are covered under the Employer's Prior Plan as of the day immediately prior to the Effective Date of the Employer adopting this Plan, shall be covered hereunder on the date of adoption provided they have elected coverage under this Plan.

EMPLOYEE(S) EFFECTIVE DATE

Eligible Employees, as defined in Eligibility, are covered under the Plan as determined by the written policies of the Employer, but not any sooner than the first of the month following the date of employment nor can the Service Waiting Period exceed ninety (90) calendar days.

DEPENDENT(S) EFFECTIVE DATE

Eligible Dependent(s), as defined in Eligibility, shall become covered under the Plan on the later of the following dates, provided the Employee has enrolled them in the Plan:

1. The date the Employee's coverage becomes effective.

2. The date the Dependent is acquired provided the Employee enrolls that Dependent within thirty-one (31) days following the date acquired. If an Employee's Dependent is employed and covered under a group plan or plans sponsored by the Dependent's Employer, the day immediately following the date such coverage terminates due to the termination of the Dependent's employment may also be deemed to be the date the Employee first acquires that Dependent and any other Dependent covered under such group plan or plans.

3. When an Employee has family coverage, an eligible newborn will be covered as of the date of birth, but no claims will be processed until the application for enrollment and any required contribution is received; the 31-day requirement to enroll a newborn Dependent will be waived. If an Employee does not have family coverage at the time of birth, the 31-day requirement to enroll a newly acquired Dependent shall apply. (Refer to Enrollment.)

TERMINATION OF COVERAGE

When coverage of an Employee and/or Dependent terminates, benefits shall not be provided for any services, supplies or treatment after termination of coverage even though such services, supplies or treatment are furnished as a result of an Illness or Injury which occurred before termination of coverage.

Except as otherwise provided herein, coverage shall terminate on the earliest of the following occurrences:

EMPLOYEE(S) TERMINATION

1. The date the Employer terminates the Plan and offers no other group health plan.

2. The date the Employee ceases to meet the eligibility requirements of the Plan.

3. The last day of the month in which employment terminates. In the case of an Employee working the night shift, the Employee's termination date is determined by the date the shift begins.

4. The date the Employee becomes a full-time, active member of the armed forces of any country, other than scheduled drills or other training not exceeding one month in any Calendar Year.

5. The last day of the month in which any required contributions have been made on the Employee's behalf.

6. The first day an Employee fails to return to work following an approved Leave of Absence.

Employees whose contract expires with the close of the current school year may be covered until the beginning of the following school year at the discretion of the Employer.

The Employer must signify an Employee's termination of employment by notifying TCSIG:

DEPENDENT(S) TERMINATION

1. The date the Employer terminates the Plan and offers no other group health plan.

2. The date the Employee's coverage terminates.

3. The date such individual ceases to meet the eligibility requirements of the Plan.

4. The last day of the month in which any required contributions have been made on his behalf.

5. The date the Dependent becomes an active, full-time member of the armed forces of any country.

6. The date Dependent coverage is discontinued under the Plan.

7. The date the Employee requests that Dependents' coverage be terminated.

8. The last day of the month in which a dependent Child attains age twenty-six (26).

LEAVE OF ABSENCE

If an Employee is absent from work because of an approved extended Leave of Absence due to Illness or Injury, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the absence started, provided the Employer and/or Employee makes the required contributions.

If an Employee is absent from work because of an approved sabbatical Leave of Absence, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the absence started, provided the Employer and/or Employee makes the required contributions.

If an Employee is absent from work because of an approved temporary Leave of Absence, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the leave started, provided the Employer and/or Employee makes the required contributions.

If an Employee is absent from work because of an approved Leave of Absence under the provisions of the Family Medical Leave Act of 1993, coverage shall be continued for the Employee and covered Dependents, but for no longer than twelve (12) weeks during any twelve (12) month period, provided the Employer and/or Employee makes the required contributions. The Break in Coverage provision below shall not apply to an Employee returning to work from an approved leave under the Act.

BREAK IN COVERAGE

A break in coverage occurs whenever an Employee remains employed by the Employer, but coverage under the Plan terminates for either the Employee or Dependents. After a break in coverage, the Employee and/or Dependents may only re-enroll in the Plan during the annual open enrollment, unless there is a status change. (Refer to Status Change.)

If the Employee fails to make the required contributions, coverage shall terminate the last day of the month in which contributions were made. When coverage terminates, the Break in Coverage provision shall apply.

REINSTATEMENT

If an Employee terminates employment with the Employer and coverage under the Plan ceases, the Employee will be subject to all Plan provisions as a new Employee if the break in service exceeds thirteen (13) weeks or twenty-six (26) weeks from an educations organization. Retirees and Retired elected officials and any Dependents of Retirees and Retired elected officials that discontinue coverage cannot re-enroll in this Plan. The Break in Coverage provision shall not apply.

SURVIVORS' BENEFITS

Subject to the terms and conditions in effect for each Employer, surviving Dependents may be eligible to continue coverage under the Plan after the death of the Employee. Survivors' benefits shall be continued after the Employee's death while contributions are continued, if required. Surviving spouse and Dependents shall be considered part of the Employee Group they were in just prior to becoming eligible for survivors' benefits.

However, coverage shall not be continued beyond the earliest of the following occurrences:

1. The date the Employer terminates the Plan and offers no other group health plan.

2. Termination of Dependent coverage under this Plan.

3. The end of the period for which contributions (if required) have been paid.

4. When the surviving spouse remarries.

5. When the surviving spouse becomes eligible for any other group health coverage.

6. When the Child ceases to meet the eligibility requirements or becomes eligible for other group health coverage.

Survivor benefits may be provided under this Plan to an Employee's Child who is born after the Employee's death, as long as coverage for the Employee's other Dependents is being continued under this Section.

For the purposes of filing a claim and payment of claims, the Employee's spouse, if living will be considered as the Employee, otherwise the Child (or the legal guardian) claiming benefits will be so considered.

This Section will not apply to a Dependent for whom a greater period of coverage is provided elsewhere in this Plan.

CONTINUATION OF COVERAGE

Government entities are subject to the continuation of coverage provisions of the Public Health Services Act which essentially duplicates the provisions of the Consolidated Omnibus-Budget Reconciliation Act (COBRA). The following is intended to comply with the Public Health Services Act.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, Accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical benefits as provided under the Plan.

QUALIFYING EVENTS

Under this provision, the following Covered Persons whose coverage would otherwise end may continue coverage under the Plan:

1. Covered Dependents of a covered Employee who dies.

2. A covered Employee and his covered Dependents upon the Employee's termination of employment (other than termination for gross misconduct) or whose work hours have been reduced to less than the minimum required for coverage under the Plan.

3. A covered spouse (and any affected covered Dependents) upon divorce or legal separation.

4. Covered Dependents of a covered Employee whose termination from the Plan is due to the covered Employee becoming eligible for benefits under Medicare.

5. A covered Dependent Child who attains the maximum age at which Dependent Children may be covered under the Plan, or otherwise becomes ineligible under the Plan's terms.

6. A covered Retiree and their covered beneficiaries whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

7. The last day of a leave under the Family Medical Leave Act.

8. The call-up of reservist in the United States military or National Guard to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered Employee or a Child's attainment of the maximum age for coverage under the Plan, the Employee or Dependent must notify the Employer of that event within sixty (60) days of the event. **Failure to provide notification to the Employer will result in the person forfeiting their right to continued coverage.**

2. The Employer must submit such notice to TCSIG or its designated representative within thirty (30) days of receipt.

3. Within fourteen (14) days of receiving notice, TCSIG or its designated representative shall advise the Employee or Dependent of his or her rights to continue coverage.

4. After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. This sixty (60) day period begins on the later of:

   A. The date coverage under the Plan would otherwise end; or

   B. The date the person receives the notice from TCSIG or its designated representative of his or her rights to continuation of coverage.

   If the Employee or Dependent chooses to have continuation of coverage, he must advise TCSIG or its designated representative in writing of this choice. TCSIG or its designated representative must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period.

5. Within forty-five (45) days after the date the person notifies TCSIG or its designated representative that he has chosen continuation of coverage, the person must pay the initial premium. The initial payment shall be the amount needed to provide coverage from the date continued benefits begin to the date that the election was made. Thereafter, premiums for the continued coverage are to be paid monthly, and are due in advance, on the first day each month.

6. The Employee, Dependent or their designated representative must pay the premium for the coverage being continued.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or Dependent Child newly acquired during continuation of coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation of coverage. A Child born to or placed for adoption with the covered Employee during the period of continuation of coverage shall be eligible for an extension of continuation of coverage due to a second qualifying event. A Child born to or placed for adoption with the former spouse of a covered Employee shall not be eligible for the extension of continuation of coverage due to a second qualifying event. The Plan shall provide a special thirty (30) day enrollment period to enroll such Child (ren).

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation of coverage, it is possible for a second qualifying event to occur, including:

1. Death of an Employee.

2. Divorce or legal separation from an Employee.

3. Employee's entitlement to Medicare.

4. Child's loss of Dependent status.

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Except as specified in Family Members Acquired During Continuation above, only a person covered prior to the original qualifying event is eligible for the second continuation period as the result of a subsequent qualifying event. A Dependent acquired during continuation of coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

For example: (1) Continuation may begin due to termination of employment. During the continuation, if a Child reaches the upper age limit of the Plan, the Child is eligible for a second continuation period. This second continuation would end no later than thirty-six (36) months from the date of the first qualifying event, (i.e., the termination of employment). (2) An Employee terminates and elects continuation of coverage for himself and his spouse. They would be allowed continuation of coverage for up to eighteen (18) months. If during the eighteen (18) months, the Employee becomes entitled to Medicare, the spouse would be eligible for additional continuation up to a total of thirty-six (36) months from the date of the first qualifying event.

WHEN CONTINUATION OF COVERAGE BEGINS

When continuation of coverage is elected, and the premium paid, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. However, for an Employee on an approved leave under the Family Medical Leave Act, continuation of coverage shall begin on the last day of the leave. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

END OF CONTINUATION

Continuation shall end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began for an Employee whose coverage ended because of a reduction of hours or termination of employment.

2. Thirty-six (36) months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the attainment of the maximum age of eligibility by a Dependent.

3. The end of the period for which premium is paid if the Covered Person fails to make a premium payment on the date specified by TCSIG.

4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.

5. The date the Covered Person becomes entitled to Medicare.

6. The date the Covered Person becomes covered under any other group health plan.

7. In the case of bankruptcy proceeding, the period until the death of the Retiree, and widows or widowers of Retirees who died before the Employer's bankruptcy are entitled to lifetime continuation of coverage. However, if a Retiree dies after the Employer's bankruptcy, the surviving spouse and Dependent Children may only elect an additional thirty-six (36) months of continuation of coverage after the death.

In the event an Employer terminates its participation in this Plan, all persons under continuation of coverage through that Employer shall transfer to the Employer's new plan, and continuation of coverage under this Plan shall cease.

EXTENSION FOR DISABLED INDIVIDUALS

Continuation of coverage may extend from eighteen (18) months to twenty-nine (29) months if the qualified beneficiary receives a determination from the Social Security Administration that the person was disabled at the time of the qualifying event, or within sixty (60) days of the qualifying event. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. In order to be eligible for the additional eleven (11) month extension, the qualified beneficiary must submit proof of the determination of disability by the Social Security Administration to TCSIG or the Claims Administrator within the initial eighteen (18) month continuation of coverage period and no later than sixty (60) days after the Social Security Administration's determination. Extended coverage will end the month that begins thirty (30) days after the person is no longer considered disabled.

MEDICARE

The term "Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Individuals who have earned the required number of quarters for Social Security benefits within the specified timeframe are eligible for Medicare Part A at no cost. Ineligible individuals age sixty-five (65) and over may purchase Medicare Part A by making application to Social Security Administration and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an Employee reaches age sixty-five (65) and is still Actively at Work, the following options are available:

   A. Continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching age sixty-five (65), or

   B. Discontinue health coverage under this Plan and enroll under the Medicare Program.

   An individual is considered to be age sixty-five (65) on the first day of the month in which his/her sixty-fifth (65th) birthday falls.

2. If the Employee elects option "A" above:

   A. And is also enrolled in Medicare, as secondary payer, Medicare may pay for some expenses not covered by this Plan.

   B. The Employee may elect to continue under this Plan as primary payer until retirement.

3. If the Employee elects option "1.B" above, no health benefits will be paid under this Plan. Medicare shall be primary payer.

4. Federal legislation also requires that the spouse, age sixty-five (65) and over of any active Employee be given the option to elect the Employer's Plan as primary payer, or Medicare as primary payer. If the affected spouse elects the benefits of this Plan as primary, the Plan shall provide benefits equivalent to the benefits available to Covered Persons under age sixty-five (65). If the spouse elects Medicare, no benefits shall be available under this Plan.

All Retirees age sixty-five (65) and older who are eligible for Medicare Part A must enroll in Medicare A and B. If any retired Covered Person is eligible for Medicare Parts A and B and fails to enroll, benefits will be paid as though he had enrolled. If the Employer elects Retirees to be eligible to participate, contributions may be Retiree or Employer paid at the discretion of the Employer. Eligible Retirees, upon retirement, shall be placed on the tiered rate structure or may be placed, with their Employer's approval, on a composite rate if they enroll two or more dependents and their former, active group is also composite. If a Retiree enrolls in both Medicare Parts A and B, TCSIG may provide a discounted contribution schedule, provided the Plan is secondary payer to Medicare.

MEDICAL EXPENSE BENEFIT

Medical expenses otherwise referred to as "Covered Expenses" means the expenses actually incurred by or on behalf of a Covered Person for the expenses listed in this Section, but only if the expenses are incurred while such person is covered under the Plan and only to the extent that the services or supplies provided are Medically Necessary for the care and treatment of the Illness or Injury suffered by the Covered Person. However, Covered Expense shall also include certain procedures which are not Medically Necessary and are specified herein.

The extent of benefits paid by the Plan for Covered Expenses is subject to the Deductible, Benefit Percentage, and Maximum Benefit as shown in the Schedule of Benefits.

DEDUCTIBLE AND BENEFIT PERCENTAGE (COINSURANCE)

Self-only Deductible:

The Calendar Year Deductible is the amount of Covered Expense which the Covered Person incurs and pays Out-of-pocket during each Calendar Year before any Benefit Percentage applies for services and supplies rendered. Charges which are not covered under the Plan, or charges which exceed the Reasonable and Allowable Amount for the service or supply rendered may not be used to satisfy the Deductible.

Family Deductible:

If in any Calendar Year covered members of a family shall have cumulatively incurred sufficient Covered Expenses to satisfy the Deductible specified, the Deductible shall be deemed to be satisfied for all covered members of the family in that Calendar Year.

Deductible Carry-Over:

In order to maintain the Internal Revenue Service (IRS) qualification for federal exemption of associated health savings accounts, the carryover of prior year last quarter Deductible expenses is not allowed.

Deductible expense shall only apply in the Calendar Year in which it occurred.

Prior Deductible and Benefit Percentage:

This Plan will provide credit for any Deductible and Benefit Percentage satisfied under a prior TCSIG Plan in the same Benefit Plan Year. If this Plan's Calendar Year Deductible and/or Coinsurance are greater than the prior TCSIG Plan, the Covered Person must satisfy the remaining Deductible and/or Coinsurance requirement of this Plan.

Benefit Percentage:

The Benefit Percentage is the portion of the Reasonable and Allowed Amount that the Plan will pay as a Covered Expense rendered by a Non-PPO or the percentage of the Negotiated Rate for PPO services. Once the Deductible is satisfied, the Plan shall pay benefits for Covered Expenses incurred during the remainder of the Calendar Year at the applicable Benefit Percentage. The Covered Person is responsible for paying the remaining percentage. The Covered Person's remaining percentage of the Covered Expenses and the Deductible applies toward their Out-of-pocket expense.

The portion of the Non-PPO's bill in excess of the Reasonable and Allowed Amount is not a Covered Expense under this Plan and is the responsibility of the Covered Person.

OUT-OF-POCKET

After the Covered Person has paid an amount equal to the Out-of-pocket expense the Plan shall pay one hundred percent (100%) of Covered Expenses for the remainder of the Calendar Year, subject to the limitations below.

If in any Calendar Year covered members of a family shall have cumulatively incurred sufficient Out-of-pocket Covered Expenses to satisfy the family Out-of-pocket expense limit, the Plan shall pay one hundred percent (100%) of Covered Expenses for the remainder of the Calendar Year for all covered family members, subject to the limitations below.

If any part of the Out-of-pocket expense limit has been paid under the prior TCSIG Plan, the Out-of-pocket expense limit of this Plan shall be reduced by that amount.

The following items do not apply toward the Out-of-pocket expense limit:

1. Any expense not covered under this Plan.

2. Expense incurred as a result of failure to obtain Pre-certification nor shall it be payable at the one hundred percent (100%) Benefit Percentage.

MAXIMUM BENEFIT

The Schedule of Benefits contains separate Maximum Benefit limitations for specified conditions. The Maximum Benefit limitations may be limited to services and/or supplies during a Calendar Year, or to the entire time the person is covered under this Plan. Once the Maximum Benefit under the Plan has been paid, no additional benefits for the limited services and/or supplies shall be paid by the Plan, except for the beginning of a new Calendar Year as applicable

HOSPITAL/AMBULATORY SURGICAL CENTER/URGENT CARE FACILITY

Inpatient Hospital admissions are subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits. (Refer to Cost Containment.)

Covered Expenses shall include:

1. Room and Board for treatment in a Hospital, including Intensive Care units (ICU), Cardiac Care Units (CCU) and similar Medically Necessary accommodations.

2. Miscellaneous Hospital services, supplies and treatments including, but not limited to:

   A. Admission fees and other fees assessed by the Hospital for rendering Medically Necessary services, supplies and treatments;

   B. Use of operating, treatment or delivery rooms;

   C. Anesthesia, anesthesia supplies and its administration by an Employee of the Hospital;

   D. Medical and surgical dressings and supplies, casts and splints;

   E. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives. **(Excluded: Donated blood or replaced blood is not a Covered Expense. Donor charges are not covered. Autologous blood or related charges such as storage fees or preparation are not Covered.)**

   F. Drugs and medicines (**Excluded: Drugs not used or consumed in the Hospital**);

   G. X-ray and diagnostic laboratory procedures and services;

   H. Oxygen and other gas therapy and the administration thereof;

   I. Physical, occupational and speech therapy services.

3. The daily Hospital rate shall be as follows:

   Routine Care: average Semiprivate rate
   Private Room: average Semiprivate rate
   ICU or CCU: all Medically Necessary charges

   A. If the Hospital only has private room facilities, private room charges will be considered Semiprivate charges.

   B. If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as Semiprivate upon written verification of the attending Physician.

4. Services, supplies and treatments described above furnished by an Ambulatory Surgical Center, or Urgent Care Facility including follow-up care provided within seventy-two (72) hours of a procedure.

EMERGENCY

If a Covered Person receives Emergency care, the Plan will pay as specified in the Schedule of Benefits for Physician, Hospital, diagnostic x-ray and laboratory services, supplies and treatment associated with the initial Emergency treatment and/or Confinement subject to the Deductible and Benefit Percentage (Coinsurance) at the Preferred Provider level of benefit.

If the Covered Person receives such initial care from a Non-PPO Hospital, in order to receive full benefits, the Covered Person shall be relocated to a PPO Hospital, as soon as it is reasonable. If the Covered Person does not relocate to a Participating Provider Hospital, the Plan's payment shall be in accordance with the Non-PPO level of benefit.

PRE-ADMISSION TESTING

Pre-Admission Testing enables the Covered Person to have necessary tests done as an Outpatient prior to a scheduled admission or Outpatient Surgery. Pre-Admission Testing for Medically Necessary tests shall be covered provided the following conditions are met:

1. The tests are ordered by a Physician.

2. The tests are performed on an Outpatient basis.

3. The tests are performed within seven (7) days prior to a Hospital Confinement or Outpatient Surgery.

AMBULANCE/EMERGENCY TREATMENT TRANSPORTATION

1. Professional, licensed ambulance service for air or ground transportation to the nearest Hospital or Ambulatory Surgical Center able to provide the necessary services.

2. In the event that a condition requires specialized Emergency treatment not available at a local Hospital, Medically Necessary transportation for such treatment is covered when ordered by a Physician. The transportation is within the United States and Canada only and must be by a regularly scheduled airline, railroad, or by licensed, air or ground ambulance. Covered transportation is only from the initial Hospital to the nearest Hospital qualified to render the special treatment.

3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

INPATIENT REHABILITATION SERVICES

Charges made by a Rehabilitation Facility are eligible under the Plan provided:

1. The Covered Person was first confined in a Hospital for at least three (3) consecutive days for the same or related condition;

2. The attending Physician recommends Inpatient Rehabilitation services;

3. The Rehabilitation Confinement begins within fourteen (14) days after discharge from that Hospital Confinement, or within fourteen (14) days after a related Rehabilitation Care Confinement; and

4. The facility is licensed in the state of jurisdiction.

Covered Expenses are:

1. Room and Board (including regular daily services and supplies furnished by the Rehabilitation Facility); and

2. Other Medically Necessary services and supplies, except professional services, ordered by a Physician and furnished by the Rehabilitation Facility including physical therapy.

PHYSICIAN/PRACTITIONER SERVICES

For Physician/Practitioner services subject to an Office visit Coinsurance or Deductible as listed in the Schedule of Coinsurance and Deductibles. All other Physician/Practitioner Services are subject to the Deductible and Coinsurance.

1. Charges of a Physician or Practitioner for medical and/or surgical services, supplies and treatment.

2. Surgical assistance provided by a Physician or Practitioner.

3. Charges of a Physician or professional anesthetist for furnishing and administering anesthetics.

4. Consultation charges requested by the attending Physician.

5. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for Diagnosis and treatment.

6. Charges of a radiologist or laboratory for Diagnosis or treatment.

7. Radiation therapy and Chemotherapy.

8. Nursing care by a licensed Nurse except for private duty nursing.

9. Charges for acupuncture therapy rendered by an M.D., D.O., D.C. or Licensed Acupuncturist for treatment of chronic pain associated with migraines, arthritis, neuritis, sprains or strains.

10. Allergy shots and allergy testing.

11. Following appropriate diagnostic alternatives and documented failure of conventional medical evaluation, biofeedback may be considered Medically Necessary in the treatment of the following conditions: chronic pain, organic muscle abnormalities, chronic anorectal dysfunction associated with incontinence and constipation, chronic pelvic muscular dysfunction associated with urinary incontinence and Raynaud's phenomenon. All other uses of biofeedback are considered Experimental and are not a Covered Expense.

TRANSPLANT COVERAGE

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Services, supplies and treatment in connection with human organ or tissue transplant procedures are covered, subject to the following conditions:

1. All other conventional methods of treatment have been engaged but were unsuccessful.

2. A second opinion may be required prior to undergoing any transplant procedure.

3. If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient shall be considered for benefits.

4. If the donor is covered under this Plan, eligible medical expenses incurred by the donor shall be considered for benefits provided the recipient is also covered under this Plan. Eligible medical expenses incurred by each person shall be treated separately for each person. (If the recipient is not covered by this Plan, the donor expenses shall not be covered by this Plan.)

5. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, shall be Covered Expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's Maximum Benefit. In no event will benefits be payable in excess of the Maximum Benefit still available to the recipient.

6. Covered Expenses of the donor which are incurred as the direct result of and within three (3) months of the transplant shall be considered expenses incurred by the donor to the extent that benefits are not provided under any other group health plan. Any fee or charge made by the donor for such organ(s) shall not be considered a covered medical expense.

7. The Reasonable and Allowable Amount for securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ shall be considered a Covered Expense.

8. Transplant coverage is subject to the provisions of large case management. The facility to perform the transplant procedure must be pre-certified by the Utilization Review Organization (URO).

FAMILY PLANNING

Family planning for the Employee, covered spouse and eligible Dependent shall include Covered Expenses incurred for abortions and elective sterilization. Infertility testing is limited to x-rays and laboratory examinations performed solely for the purpose of diagnosing infertility.

PREGNANCY

Expenses incurred for medical care and treatment rendered to an Employee, their enrolled spouse or eligible Dependent for Pregnancy shall be considered for benefits under this Plan subject to all of the Plan's terms and conditions applicable to medical care and treatment of an Illness.

The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

The attending Physician, after consultation with the mother, may release the mother before these time periods have expired.

BIRTHING CENTER

Services and supplies rendered at a Birthing Center, as defined herein, to include care provided by a certified Nurse midwife with supervision by a Physician or by nurses with specialized training to monitor labor, delivery, and after delivery care shall be a Covered Expense and payable as shown in the Schedule of Benefits.

NEWBORN SERVICES

Covered Expenses for a well newborn Child incurred for Hospital services to include routine nursery charges, initial Physician examination and circumcision, while the mother is confined for delivery shall be added to Covered Expenses of the mother to determine allowable benefits payable (one Deductible) provided the natural mother is enrolled under the Plan.

Payment for Covered Expenses for an ill newborn Child incurred for Hospital and Physician services shall be made on the same basis as for any other Illness for the first thirty-one (31) days immediately following birth. After the thirty-first (31st) day, benefits shall be payable only if the Employee has properly enrolled the newborn Child for Dependent benefits and paid any required contributions**. If the newborn Child is still confined in the hospital one Deductible shall apply. After the thirty-first (31st) day, benefits shall be payable only if the Employee has properly enrolled the newborn Child for Dependent benefits and paid any required contributions.**

If the newborn Child is discharged from the hospital, all future charges including new hospital and/or Physician services shall be payable only if the Employee has property enrolled the newborn Child for Dependent benefits and paid any required contributions, subject to the dependent Child's Deductible.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered Expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

CHRISTIAN SCIENCE SERVICES

Services rendered in accordance with the healing practices of Christian Science (except those rendered primarily for rest or spiritual guidance):

1. Present treatment and absent treatment by a Christian Science Practitioner subject to the same terms and conditions as if such charges had been made by a Physician;

2. Room and Board during Confinement for healing purposes in a Christian Science Sanatorium subject to the same terms and conditions as if such charges had been incurred in a Hospital;

3. Private duty nursing services by a Christian Science Nurse subject to the same terms and conditions as if such charges had been made by a Registered Nurse (R.N.).

SKILLED NURSING FACILITY

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Charges made by a Skilled Nursing Facility are eligible under the Plan provided:

1. The Covered Person was first confined in a Hospital for at least three (3) consecutive days;

2. The attending Physician recommends skilled nursing Confinement for a convalescence from a condition which caused that Hospital Confinement, or a related condition;

3. The skilled nursing Confinement begins with fourteen (14) days after discharge from a Hospital Confinement, or within fourteen (14) days after a related skilled nursing Confinement; and

4. The Covered Person is under a Physician's continuous care and he certifies that the Covered Person must have twenty-four (24) hours-per-day nursing care.

If the Covered Person is discharged from the Skilled Nursing Facility and again becomes an Inpatient in such facility within fourteen (14) days of the original discharge, it is considered one (1) period of Confinement.

Covered Expenses shall include:

1. Room and Board (including regular daily services and supplies furnished by the Skilled Nursing Facility); and

2. Other services and supplies, except for professional services, ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care.

The Plan shall cover up to the lesser of the facility's regular daily Semiprivate rate or fifty percent (50%) of the most common daily Semiprivate rate of the Hospital in which most recently confined.

HOME HEALTH CARE

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Home Health Care enables the Covered Person to receive treatment by a Home Health Care Agency in his home for an Illness or Injury in lieu of being confined in a Hospital or Skilled Nursing Facility. Home Health Care services include:

1. Part-time or intermittent nursing care by or under the supervision of a graduate registered Nurse (R.N.);

2. Part-time or intermittent Home Health Aide Services consisting primarily of caring for the Covered Person;

3. Physical therapy, occupational therapy and speech therapy;

4. Social services counseling;

5. Drugs, medicines, dressings, and laboratory tests ordered by a Physician.

Home Health Care shall be limited to the number of visits shown in the Schedule of Benefits. A visit by a member of a Home Health Care Agency and four (4) hours of Home Health Aide Service shall each be considered one Home Health Care visit.

The Covered Person must be under the continuing care of a Physician. The attending Physician must certify that the proper treatment of the Illness or Injury would require Confinement as an Inpatient in the absence of Home Health Care.

The Plan will <u>not</u> pay for:

1. Any services of a Close Relative or someone who normally lives in the Covered Person's home;

2. Any Custodial Care (services which are provided primarily to assist an individual in the activities of daily living, e.g., meals and personal grooming);

3. Private duty nursing care in excess of the part-time or intermittent care defined herein;

4. Any food, food supplements, home delivered meals, transportation expense, or housekeeping services.

HOME INFUSION THERAPY

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Home infusion therapy Provider services are subject to Pre-certification to determine medical necessity. (See Cost Containment.) The following services and supplies when provided by a home infusion therapy Provider in the home for the intravenous administration related to Illness or Injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery (not to exceed a fourteen (14) day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

3. Hospital and home clinical visits related to the administration of infusion therapy, skilled nursing services including those provided for: (a) patient or alternative care giver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for Durable Medical Equipment; maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

HOSPICE CARE

Subject to the Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Hospice benefits for Inpatient Confinement and Home Health Care shall be covered only if the Covered Person's attending Physician certifies that:

1. The Covered Person is terminally ill, and

2. The Physician has certified the life expectancy is less than six (6) months.

Covered Expenses are:

1. Confinement in a Hospice.

2. Ancillary charges furnished by the Hospice while the person is confined.

3. Medical supplies, appliances, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.

4. Physician services and/or nursing care by a registered Nurse, a licensed practical Nurse, or a licensed vocational Nurse.

5. Home Health Aide Services.

6. Nutrition services.

7. Counseling services by a Practitioner or a licensed pastoral counselor.

8. Physical therapy, occupational therapy and speech therapy.

9. Respite care under the Hospice program is a short-term Inpatient stay in a facility. The Inpatient Confinement gives temporary relief, a respite, to the person who regularly assists with home care. Each Inpatient respite care stay is limited to no more than five (5) days in a row.

10. Bereavement counseling is a supportive service to Covered Persons in the deceased's immediate family after the death of such terminally ill person. Such visits are to assist the Covered Persons in adjusting to the death. Benefits shall be payable for bereavement care provided:

    A. On the date immediately before death, the terminally ill person was covered under the Plan, a member of the covered family, and receiving Hospice care benefits, and

    B. Charges for such services are incurred by the Covered Persons within three (3) months of the terminally ill person's death. Hospice benefits are limited as stated in the Schedule of Benefits.

No benefits are payable for Hospice care or services which are excluded under the Plan's limitations and Exclusions. Any Covered Expense paid under Hospice benefits will not be considered a Covered Expense under any other provision of this Plan.

DURABLE MEDICAL EQUIPMENT

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Pre-certification is required on Durable Medical Equipment over two thousand dollars ($2,000.00).

Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment which is prescribed by a Physician and required for therapeutic use by the Covered Person shall be a Covered Expense. Equipment ordered prior to the Covered Person's Effective Date of coverage is not covered, even if delivered after the Effective Date of coverage. Repair or replacement of purchased Durable Medical Equipment which is Medically Necessary due to normal use, or growth of a Child will be considered a Covered Expense.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the Covered Person's medical needs. Any charges over the usual charge will be the responsibility of the Covered Person.

PREVENTIVE CARE SERVICES AND WELLNESS

NOTE: *The Preventive Care services identified through the links below are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Coverage for one (1) routine physical examination/visit per Calendar Year for the Employee, covered spouse and eligible Dependents to include Physician services, diagnostic laboratory, and x-ray services which shall be limited for each as specified in the Schedule of Benefits. Immunizations will be included as recommended by the Center for Disease Control for Children and adults. **Foreign travel immunizations are not covered.**

Virtual physical (full-body CAT scan), CT body scanning, coronary artery scoring, high resolution-low dose lung screening, full body screening, brain scan, vital views and full body scans or similar named scans will not be a Covered Expense. Scans ordered/referred by a Physician for an active Diagnosis that requires this type of scan will be a Covered Expense.

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

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

A description of Preventive and Wellness Services can be found at:
https://www.uspreventiveservicestaskforce.org, or https://www.cdc.gov/vaccines/schedules/easy-to-read/index.html for more details.

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

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies, and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Physical therapy and occupational therapy services are subject to a Maximum Benefit as specified in the Schedule of Benefits. The following services provided by a Physician under a treatment plan which offers a reasonable expectation of significant improvement are covered:

1. Physical therapy provided on an Outpatient basis for treatment of Illness or Injury include the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an Outpatient basis when the ability to perform daily life tasks has been lost or reduced by Illness or Injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

SPEECH THERAPY

Speech therapy must be ordered by a Physician to aid restoration due to Illness or Injury. Covered Expenses shall include services of a speech therapist. Covered Expenses for speech therapy shall not include services for an impairment due to mental, psychoneurotic or personality disorder.

For Physician/Practitioner services an Office visit Coinsurance or Deductible will apply. All other Physician/Practitioner Services are subject to the Deductible and Coinsurance.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Subject to Pre-certification. Failure to obtain Pre-certification shall result in a reduction of benefits.

Surgical and non-surgical treatment and/or services related to temporomandibular joint (TMJ), or myofascial pain syndrome, or other associated disorders, except for orthodontia, shall be a Covered Expense subject to Deductible and Coinsurance. This shall apply whether treatment is provided by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Medicine (D.M.D.), Dentist (D.D.S.) or Hospital.

ORAL SURGERY

Oral Surgery shall be limited to the following procedures:

1. Excision of tumors or cysts from the mouth;

2. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures);

3. Treatment of fractures of facial bones;

4. External incision and drainage of cellulitis;

5. Incision of accessory sinuses, salivary glands or ducts.

DENTAL SERVICES

Charges in connection with dental work, dental x-rays, dental examination, or oral Surgery (including Hospital Room and Board, necessary services and supplies, and charges of a Physician and surgeon) for repair of sound natural teeth or other body tissue provided:

1. It is a result of an Accident Bodily Injury occurring while covered, and

2. The treatment is complete within six (6) months after the Injury.

A sound natural tooth is free of decay, but may be restored by fillings, has a live root and does not have a cap or crown.

PROSTHESES

Purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. An external breast prosthesis shall be covered once every three (3) Calendar Years, the support garment two (2) in each six (6) month period, up to a maximum of $50 each, and the first permanent internal breast prosthesis necessary because of a mastectomy shall also be a Covered Expense. A prosthesis ordered prior to the Covered Person's Effective Date of coverage is not covered, even if delivered after the Effective Date of coverage. Repair or replacement of a prosthesis which is Medically Necessary due to normal use, or growth of a Child will be considered a Covered Expense. Wigs or artificial hair pieces as a result of chemotherapy or radiation therapy will be considered a Covered Expense, up to a maximum of $250.

SPECIAL EQUIPMENT AND SUPPLIES

Covered Expenses shall include Medically Necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy bags and supplies required for their use; catheters; test strips and blood sugar measurement devices; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract Surgery; soft lenses or sclera shells intended for use in the treatment of Illness or Injury of the eye; support stockings, such as Jobst stockings and surgical dressings ordered by a professional Provider in connection with medical treatment. **Common first aid supplies and over-the-counter products are not Covered Expenses.**

COSMETIC SURGERY

Cosmetic Surgery shall be a Covered Expense provided:

1. A Covered Person's Injury resulted from an Accident which occurred while covered for benefits hereunder and, as a result requires Surgery. Cosmetic Surgery and treatment must be for the purpose of restoring the Covered Person to his normal body functions immediately prior to the Accident.

2. It is required to correct a congenital disease, developmental condition or anomaly (which has resulted in a functional defect) of a Dependent Child.

3. Reconstruction of the breast on which the mastectomy was performed, Surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and physical complications for all stages of mastectomy, including lymphedemas. The replacements of such items which are not Medically Necessary are not Covered Expenses.

MENTAL HEALTH DISORDERS/CHEMICAL DEPENDENCY

Mental Health Disorders/Chemical Dependency benefits are limited as shown in the Schedule of Benefits. Benefits are subject to the Plan Exclusions.

TCSIG has contracted with a managed psychiatric health care and Chemical Dependency services Network (Network) to provide Covered Persons with services and supplies for the treatment of Mental Health Disorders/Chemical Dependency.

All treatment, Inpatient and Outpatient, for Mental Health Disorders and Chemical Dependency must be pre-certified by the managed psychiatric health care and Chemical Dependency services Network. For Emergency Admission, the Covered Person or their designated representative must obtain certification within seventy-two (72) hours.

Inpatient Services include day treatment, residential treatment or partial hospitalization which provides all the treatment and services of Inpatient Mental Health Disorders or Chemical Dependency treatment, except the Covered Person does not remain in the facility overnight. The Covered Person is treated in the facility for at least four (4) hours, but not greater than seventeen (17) continuous hours per treatment day. The Covered Person is treated in a structured Outpatient program through a licensed treatment facility and the treatment is pre-certified by the Network.

SPINAL MANIPULATION

Covered Expense includes initial consultation, x-rays and treatment (but not maintenance care), subject to the Maximum Benefit as specified in the Schedule of Benefits.

PRESCRIPTIONS

The Plan requires the use of a Network pharmacy.

Prescription Drugs and medications prescribed by a Physician or Practitioner, including insulin, test strips, lancets, syringes and needles for insulin which are purchased through the prescription program shall be a Covered Expense. **Vitamins, baby formula, food or nutritional supplements, infertility medications or contraceptives are not covered unless designated by the U.S. Preventive Task Force grade of A or B recommendations or Health Resources and Services Administration.**

A generic or formulary Drug will automatically be substituted for a brand name unless there are health reasons and the Physician indicates "Dispense as Written". A letter of medical necessity will be required from the prescribing Physician.

If the Covered Person requests a brand name Drug when a generic is available and Physician has NOT provided written evidence of medical necessity, the Covered Person will be liable for the difference in cost between the name brand and the generic in addition to the brand name Coinsurance.

Pharmacy Network:

TCSIG has contracted with a pharmaceutical Network to provide prescription Drugs and medicines. The Plan shall pay the Covered Expenses after the Covered Person has paid the applicable Coinsurance as specified in the Schedule of Benefits. Quantities are limited to a thirty-one (31) day supply. A ninety (90) day supply is available at contracting pharmacies.

Mail Order Program:

TCSIG has also contracted with a company to provide maintenance prescription Drugs at a discounted rate through a mail order program. If the Covered Person requires a maintenance type Drug, the Physician may write the prescription for up to a ninety (90) day supply.

PODIATRY SERVICES

Covered Expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) assessed by a governmental entity for services, supplies and/or treatments rendered by a professional Provider; Physician; Hospital; facility or any other health care Provider shall be a Covered Expense under the terms of the Plan.

HABILITATIVE

Covered Expenses include physical therapy, occupational therapy and speech pathology**.** These services could also include devices that are provided for a person to attain, maintain, or prevent deterioration of a skill of a skill or function *never learned or acquired due to a disabling condition*. These services when provided for autism spectrum disorder are not a covered benefit. This benefit is separate from Rehabilitation services. Maximum Benefit is 20 visits per Calendar Year

REHABILITATIVE

Covered Expenses include physical therapy, occupational therapy and speech pathology**.** These services could also include devices that are provided to help a person regain, maintain, or prevent deterioration of a skill or function *that has been acquired but then lost or impaired due to Illness, Injury, or a disabling condition*. This benefit is separate from habilitation services.

PLAN EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person for the following:

1. Charges for services, supplies or treatment from any Hospital or agency owned or operated by any United States federal, state, or local governmental agency, or any government outside the United States unless payment is legally required.

2. Charges for services, supplies or treatment for Illness or Injury which is caused by or attributed to war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

3. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the Covered Person fails to claim rights to such benefits.

4. Charges in connection with any Illness or Injury arising out of, or in the course of, any employment for wage or profit.

5. Charges made for services and supplies which are not Medically Necessary for the treatment of Illness or Injury, or which are not recommended and approved by the attending Physician, except as specifically stated herein, or to the extent that the charges exceed the Reasonable and Allowable Amount.

6. Charges for treatment of any intentionally self-inflicted Illness or Injury, whether the individual treated was sane or insane at the time the incident occurred, including suicide or attempted suicide.

7. Charges for illness or injury resulting from the commission of a crime by the Covered Person while engaged in an illegal felonious act.

8. Charges resulting from the release of nuclear energy, whether or not the result of war, when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy.

9. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Covered Person resides at the time the expenses are incurred.

10. Charges for treatment, services, or supplies that are provided due to a court order. This Exclusion does not pertain to eligibility extended as a result of a Qualified Medical Child Support Order.

11. Charges for services rendered and/or supplies received prior to the Effective Date or after the termination date of an individual's coverage.

12. Any services or supplies for which the Covered Person is not legally required to pay or which no charge is made to the Covered Person in the absence of coverage.

13. Medical or Surgical Procedures, Drugs, medical supplies, medical devices or medical equipment which are Experimental, Investigational, or do not meet accepted standards of medical practice. TCSIG shall maintain discretionary authority to determine whether a particular procedure or treatment is Experimental or Investigational. TCSIG shall rely upon competent medical opinion and reference manuals utilized by the Claims Administrator and the Utilization Review Organization (URO) in making a determination.

14. Charges incurred outside the United States if the Covered Person traveled to such a location for the purpose of obtaining medical services, prescription Drugs or supplies.

15. Charges for services rendered by a Physician or Practitioner if such professional is a Close Relative of the Covered Person or resides in the same household of the Covered Person.

16. Charges for services, supplies or treatment rendered by Physicians or professional Providers beyond the scope of their license; for any treatment, Confinement or service which is not recommended by or performed by an appropriate professional Provider.

17. Charges for injuries suffered by a Covered Person which are subject to third party liability or subrogation rights if the Covered Person fails to provide information as specified in Subrogation/Third Party Liability.

18. Reversal of sterilization procedures.

19. In vitro fertilization, artificial insemination, induced ovarian hyperstimulation, or embryonic implantation procedures, and other direct attempts to induce Pregnancy.

20. Expenses for the medical treatment of infertility or infertility Drugs. Infertility testing is subject to the provisions under Medical Expense Benefit.

21. Over-the-counter birth control devices, contraceptives or medications used for contraceptive purposes; however, prescribed birth control pills and other prescribed hormonal contraceptive methods, as well as the implantation and removal of an intrauterine device (IUD) are covered.

22. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, Surgery, medical or psychiatric treatment or charges in connection with sexual dysfunction or inadequacies, however, erectile dysfunction medications are a covered benefit.

23. If this Plan is secondary, the primary coverage must be used first. If the Covered Person does not abide by the primary plan's guidelines for Pre-certification and contracted Providers, this Plan will exclude the expenses incurred for any penalty and/or reduction of benefits incurred for the failure to obtain Pre-certification, or for non-participating services.

24. Charges not deemed to be Medically Necessary by the Utilization Review Organization (URO).

25. Hospital Confinement principally for observation, diagnostic evaluations, physical therapy, x-rays or laboratory tests when such services or procedures can be safely done on an Outpatient basis.

26. Charges for services, supplies or treatment for hyperkinetic syndromes, attention deficit disorders, behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, autistic disease or hospitalization for environmental change. However, the initial examination, office visit, initial diagnostic testing to determine the Illness and the attention deficit disorders medications and the medication management charges shall be a Covered Expense.

27. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of Diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care. However, TCSIG sponsored disease management programs are a covered benefit.

29. Except as specifically stated in Medical Expense Benefit, charges for or in connection with: treatment of Injury or disease of the teeth; oral Surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

30. Optometric services, dispensing optician's services, orthoptics, eyeglasses, contact lenses, routine eye examination and eye refractions for the fitting of glasses, except as specifically stated under Medical Expense Benefit. Any eye Surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism; contact lenses and eyeglasses required as a result of this Surgery.

31. Routine foot care including treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, corns, calluses, fallen arches and trimming of toenails (except the removal of nail roots), bunions (except open cutting operations).

32. Charges for services or supplies which constitute personal comfort, hygiene or beautification items; television or telephone use; education, training, and bed and board while confined to an Institution for training; a place of rest, a place for the aged, a nursing home or Institution of like character, nor for Custodial Care.

33. Charges for telephone consultations, except when obtained from a telemedicine provider; completion of claim forms; charges associated with missed appointments.

34. Expenses for nonprescription Drugs and medicines, vitamins, cosmetic and dietary aids, food or nutritional supplements, baby formula even though a prescription number has been assigned except as recommended by the US Preventive Services Task Force grade of A or B. Amphetamines when prescribed as a dietary aid will not be considered a Covered Expense.

35. Charges for orthopedic shoes (except when they are an integral part of a leg brace), shoe inserts, orthotic appliances or other supportive devices.

36. Charges incurred for air purifiers, air conditioners, humidifiers, exercise equipment, water purifiers, whirlpools, heating pads, hot water bottles, allergenic pillows or mattresses, and waterbeds.

37. Charges incurred for escalators or elevators, saunas or swimming pools, professional medical equipment such as blood pressure kits, or supplies or attachments for any of these items.

38. Charges incurred for therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use.

39. Expenses in connection with the care or treatment of, or Surgery performed for a cosmetic procedure, except as specifically provided for herein.

40. Services, supplies or treatment for weight reduction by diet control, Surgery or behavior modification with or without medication.

41. Replacement of casts, splints, braces or similar devices damaged as a result of negligence.

42. Charges for the fitting, purchase, repair or replacement of a hearing aid.

43. Premarital examinations, pre-employment examinations, sports physicals or aviation examinations unless concurrent and included with annual Routine Physical Examination.

44. Any treatment or service which is covered by no-fault (automobile) state provisions or other similar legislation.

45. Charges for marriage counseling.

46. Immunizations and inoculations if given for foreign travel.

47. Christian Science treatment or services rendered primarily for rest or spiritual guidance.

48. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches except for smoking cessation programs through Delta TeamCare and treatments recommended by the US Preventive Services Task Force grade of A or B and obtained with a prescription.

49. Charges for services or supplies merely for the convenience of the Covered Person, the Physician, or Practitioner.

50. Any prescription provided by a pharmacy other than through the contracted pharmacy Network or the mail order program, except as otherwise specified for out of service area.

51. Any prescription which does not have FDA approval. Any prescription filled in excess of the amount specified by the Physician or any prescription or refill dispensed after one year from the Physician's original order. Amounts that exceed a thirty-one (31) day supply are excluded, except the mail order and Retail 90 Drug program which may provide up to a ninety (90) day supply.

52. Charges for naturopathy, homeopathy treatment or Drugs, hypnotism, massage therapy or aversion therapy.

53. Home nursing care except as provided under Home Health Care or Hospice.

54. Private duty nursing care.

55. Certain charges for organ donor expenses (see Transplant Coverage.)

56. Virtual physical (full-body CAT scan), CT body scanning, coronary artery scoring, high resolution-low dose lung screening, full body screening, brain scan, vital views and full body scans or similar named scans will not be a Covered Expense. Scans ordered/referred by a Physician for an active Diagnosis that requires this type of scan will be a Covered Expense.

57. Covered Expenses for speech therapy shall <u>not</u> include services for an impairment due to mental, psychoneurotic or personality disorder.

58. Common first aid supplies and over-the-counter products are not Covered Expenses.

59. The replacement of items which are not Medically Necessary are not Covered Expenses.

CLAIM PROCEDURE AND PAYMENT OF BENEFITS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Covered Person's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Covered Persons complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s).

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

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because of this Plan's design Pre-service Urgent Care claims will not be filed with the Plan; Post-service claims will instead be filed after the urgent care is provided.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Covered Person's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Covered Person, hinder the Covered Person's ability to regain maximum function (compared to treatment without delay), or subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Covered Person is urged to obtain the applicable care without delay and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Covered Person must comply with the Plan's requirements with respect to notice required after receipt of treatment and must file the claim as a Post-service Claim, as herein described.

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

2. Concurrent Claims. If a Covered Person requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Covered Person must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Covered Person, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Covered Person must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

Written proof that expenses eligible for Plan reimbursement and/or payment were incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. Although a Provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Covered Person. Claims must be submitted to the Claims Administrator within ninety (90) days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as reasonably possible. The Provider of service may submit claims to the Claims Administrator on behalf of the Covered Person. However, the Covered Person is ultimately responsible to ensure claims are submitted in a timely manner. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Covered Person or entities submitting claims to the Plan on the Covered Person's behalf.

Claims for benefits under the Plan shall conform to the following procedures:

1. A medical claim form must be submitted for all claims where the Covered Person paid the Provider directly.

2. Employees must provide to the Claims Administrator any information concerning any other group health coverage for all covered family members.

3. All bills submitted for benefits must contain the following:

   A. Name of patient.

   B. Name of Employee.

   C. Name, address and tax identification number of Provider.

   D. Employee Social Security number or Identification number.

   E. Date of service.

   F. Diagnosis.

   G. Description of service or procedure number.

   H. Charge for service.

4. Claims submitted for prescription Drugs must include the pharmacy receipt which contains the following:

   A. Name of the patient.

   B. Name of Employee.

   C. Employee Social Security number or identification number.

   D. Name and address of the pharmacy.

E. Date of purchase.

F. The cost.

G. Prescription number and name of prescription.

Cash register receipts, credit card copies, labels from containers and canceled checks are not acceptable.

5. Claims not submitted within twelve (12) months of the date of incurred liability shall be denied.

NOTICE OF CLAIM

Failure to file a claim form and an itemized bill within ninety (90) days shall not invalidate or reduce any claim for benefits if it shall be shown that: (1) it was not reasonably possible to file within that time; (2) and that the claim was filed as soon as possible, but no later than twelve (12) months after the loss occurred or commenced, unless the Covered Person is legally incapacitated. Upon termination of the Plan, final claims must be received within thirty (30) days of termination.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Covered Person of the request for additional information. Failure to do so may result in claims being declined or reduced.

PAYMENT OF BENEFITS

Benefits are payable to the Employee whose Illness or Injury, or whose Dependent's Illness or Injury is the basis of an incurred claim under this Plan. Subject to any written direction of the Employee through an application or otherwise, all or a portion of any benefits provided by the Plan for medical services may, at the Plan's option, and if Assignment of Benefits has been made by the Covered Person, be paid directly to the Provider of service.

CLAIMS REVIEW PROCEDURES

Benefit Decisions:

The Claims Administrator will notify you of benefit decisions under the plans (i.e., in the Explanation of Benefits) in accordance with the following provisions that are required by law.

Pre-Service Claims

Pre-Service Urgent Care Claims:

In the case of a claim involving urgent care, the Claims Administrator will notify you of a plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical circumstances, but not later than 24 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If you fail to provide sufficient information for a benefit determination, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

Notification of any Adverse Benefit Determination relating to urgent care claims will be made in the manner as described below. The Claims Administrator will notify you of a Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. a Plan's receipt of the specified information, or
2. the end of the period that you were given to provide the specified additional information.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

Pre-service Non-urgent Care Claims:

1. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Care Claims:

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by a plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an Adverse Benefit Determination. The Claims Administrator will notify you, in the manner described below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical circumstances, and the Claims Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, will be made in the manner described on the following pages, and appeal will be governed by the appeals process also described later in this section, as appropriate.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is claim involving non-urgent care will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).

Post-Service Claims:

1. In this situation, the Claims Administrator will notify you, in the manner described below, of a plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of a plan and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension

will specifically describe the required information, and you will be given at least 45 days from receipt of the notice within which to provide the specified information.

2. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Notification of a Determination:

The Claims Administrator will provide you with written or electronic notification of any Adverse Benefit Determination, except as otherwise described below. The notification will set forth, in a manner written to be understood by you:

1. information sufficient to allow the Covered Person to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. reference to the specific Plan provisions on which the determination is based;
3. specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary,
5. a description of a plan's review procedures and the time limits applicable to such procedures,
6. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request).
9. if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar Exclusion or limit, either an explanation of the scientific or critical judgment for the determination, applying the terms of a plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request,
10. in the case of an Adverse Benefit Determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims,
11. in the case of an Adverse Benefit Determination concerning a claim involving urgent care, the information described above may be provided to you orally within the time-frame prescribed under the Urgent Care Claims section, provided that a written or electronic notification in accordance with the guidelines set forth above is furnished to you not later than three days after the oral notification.

Calculating Time Periods:

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

Adverse Benefit Determination: Right to an Appeal:

The term Adverse Benefit Determination means any of the following: a denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim (in whole or in part) including determinations of a Covered Person's eligibility, the application of any review under the Plan, determinations that an item or service is Experimental/investigational or not medically necessary or appropriate, determinations that the benefit is not covered by the terms of the Plan, source of Injury, Network or other Exclusion on otherwise covered benefits.

An Adverse Benefit Determination includes both pre-service and post-service claims and any rescission of coverage, whether or not there is an immediate adverse effect on any particular benefit. Upon receiving an adverse benefit decision, you will have the option to receive an internal (two levels) and, if necessary, an external review, as outlined in the next two sections.

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

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

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Address for Internal and External Claim Appeals:

Medical Plans: An appeal or any information regarding an appeal must be sent in writing to the Claims Administrator:

Delta Health Systems
PO Box 1931
Stockton, CA 95201-1931

Prescription Plan: An appeal or any information regarding an appeal must be sent in writing to the pharmacy Network:

ProAct, Inc.
6333 Route 298 - Suite 210
East Syracuse, NY, 13057

Internal Appeal (Level 1)

You will have a reasonable opportunity for a full and fair review of your claim and Adverse Benefit Determination. A full and fair review will consist of:

1. Providing you the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits, and in possession of the Plan Administrator or Claims Administrator.

2. Providing you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

3. Providing for a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Full and Fair Review:

In addition, a full and fair review will consist of:

1. providing you with not later than 180 days following receipt of an Adverse Benefit Determination within which to appeal the determination,
2. providing for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the plans who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual, and
3. providing, in the case of a claim involving urgent care, for an expedited review process pursuant to which:
   A. a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by you; and
   B. all necessary information, including a plan's benefit determination on review, will be transmitted between a plan and you by telephone, facsimile, or other available similarly expeditious method.
4. that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Claims Administrator or pharmacy Network shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
5. upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
6. that a Covered Person will be provided, upon request: (a Covered Person information regarding any voluntary appeals procedures offered by the Plan; (b) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and (c) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.
7. the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

Timing of Benefit Notification on Review:

The Claims Administrator will notify you of a plan's benefit determination on review in the following manner, as appropriate.

1. **Urgent Care Claims:** In the case of a claim involving urgent care, the Claims Administrator will notify you, in the manner described below, of a plan's benefit determination on review as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by a plan.

2. **Pre-Service Claims:** In the case of a pre-service claim, the Claims Administrator will notify you, in the manner described on the next page, of a plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. The notification will be provided not later than 30 days after receipt by a plan of your request for review of an Adverse Benefit Determination.

3. **Concurrent Claims:** The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.

4. **Post-Service Claims:** In the case of a post-service claim, the Claims Administrator will notify you, in the manner described below, of a plan's benefit determination on review within a reasonable period of time. The notification will be provided not later than 30 days after receipt by a plan of your request for review of an Adverse Benefit Determination.

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

Information Included in Benefit Notification on Review:

The Claims Administrator will provide you with written or electronic notification of a plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification will set forth, in a manner written to be understood by you:

1. the specific reason or reasons for the adverse determination,
2. reference to the specific plan provisions on which the benefit determination 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 your claim for benefits.
4. a statement describing any voluntary appeal procedures offered by a plan and your right to obtain the information about such procedures,
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request,
6. if in the case of a denial based on a medical necessity or experimental treatment or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of a plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request, and
7. the following statement, "you and your plan may have other voluntary alternative dispute resolution options, such as mediation."
8. a description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary.

The plans are administrated by the appointed Claims Administrator on behalf of the plan sponsor as described in this section.

Internal Appeal (Level 2)

If your appeal of a post-service claim is denied, you or your authorized representative may request further review by the Plan Administrator. This request for a second-level appeal must be made, in writing, within 30 days of the date you are notified of the original appeal decision. For post-service claims, this second-level review is mandatory.

The Plan Administrator will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information. A level two appeal is subject to the same submission and response guidelines as a level one appeal.

If the Adverse Benefit Determination was based, in whole or in part, on a medical judgment, including determinations that treatments, Drugs, or other services are experimental/investigational, or not medically necessary or appropriate, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the Adverse Benefit Determination nor the initial appeal denial and who is not a subordinate of any such individuals.

Second-level appeals of post-service claims will be decided by the Plan Administrator within a reasonable period of time, but not later than 30 days after the Plan Administrator receives the appeal. The Plan Administrator's decision will be provided to you in writing.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Covered Person will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Covered Person may proceed immediately to the External

Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Covered Person must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Covered Person as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Covered Person, and the violation is not reflective of a pattern or practice of non- compliance.

If a Covered Person believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Covered Person may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Covered Person with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

External Claim Procedures:

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

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard External Review:

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

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

2. <u>Preliminary review</u>. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

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

444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Covered Person to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

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

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

Expedited External Review:

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

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

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

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

Decision on Review:

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

Binding Arbitration:

The Participant and the Plan Administrator (the "Parties") agree that any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Parties agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Parties agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted under the Rules of the American Health Lawyers Association ("AHLA") Alternative Dispute Resolution Service ("Rules"). If, for any reason, AHLA is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the AHLA Rules. If the arbitration is not conducted by AHLA, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

No part of this Binding Arbitration provision is meant to limit the Participant's right to seek public injunctive relief in any forum. If any portion of this Binding Arbitration provision is found to be unenforceable or illegal, it can be severed, and the other provisions shall remain in full force and effect.

Appointment of Authorized Representative

A Covered Person may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Covered Person, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Covered Person's treating health care Practitioner to act as the Covered Person's authorized representative without completion of the authorized representative form.

Should a Covered Person designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Covered Person, unless the Plan Administrator is otherwise notified in writing by the Covered

Person. A Covered Person can revoke the authorized representative at any time. A Covered Person may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Covered Person shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

FOREIGN CLAIMS

In the event a Covered Person incurs a Covered Expense in a foreign country, the Covered Person shall be responsible for providing the following to the Claims Administrator before payment of any benefits due are payable:

1. The claim form, Provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars at the conversion rate applicable as of the date of service.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

INCAPACITY

If in the opinion of the Claims Administrator, a Covered Person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to TCSIG of the qualification of a guardian or personal representative for his estate, TCSIG may, at its discretion, direct any and all such payments to be made to the Provider of medical services or other person providing for the care and support of such individual. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Claims Administrator will not be required to see to the application of the money so paid.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made by TCSIG in any amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, TCSIG shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as TCSIG shall determine: any individual to or for or with respect to whom such payments were made, any insurance companies, and any other organizations. TCSIG has the right to apply recovery to any additional benefits payable under this Plan.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The Plan, at its own expense, shall have the right to require an examination of an individual covered under this Plan by a Physician designated by TCSIG when and as often as it may reasonably require during the pendency of a claim.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Covered Person is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plans, pay a reduced benefit. When Coordination of Benefits occurs, the total benefit payable by all plans shall not exceed one hundred percent (100%) of "Allowable Expenses." Only the amount paid by this Plan shall be charged against the Maximum Benefit.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Other Plan(s)" means any plan, policy or coverage providing benefits or services for, or by reason of health, medical or dental care treatment. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to, Hospital indemnity benefits and Hospital reimbursement-type plans;

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

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

4. A licensed Health Maintenance Organization (HMO);

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Automobile insurance coverage on an automobile leased or owned by the Employer;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an Employer or deductions made by an Employer from a person's compensation or retirement benefits;

10. Labor/management trusteed, union welfare, Employer organization or Employee benefit organization plans.

"This Plan" shall mean that portion of the Employer's Plan which provides benefits that are subject to this provision.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

“Reasonable and Allowable Amount”. Reasonable and Allowable Amount does not include expenses contained in the Plan Exclusions section of this Plan.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a Covered Person for each Claim Determination Period for the Allowable Expenses incurred. The benefits paid under this Plan shall be reduced so that the sum of benefits paid by all plans does not exceed one hundred percent (100%) of total Allowable Expenses incurred.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION

Each plan shall make its claim payment according to the following order of benefits determination:

1. No Provisions for Coordination of Benefits
   If the Other Plan contains no provisions for Coordination of Benefits, then its benefits shall be paid before all Other Plans.

2. Employee/Dependent
   The plan which covers the Covered Person as an Employee (or named insured) pays as though no Other Plan existed. Remaining recognized charges are paid under a plan which covers the Covered Person as a Dependent.

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   Subject to the Eligibility provisions of this Plan, when parents are separated or divorced, the birthday rule does not apply. The following shall apply:

   A. If a court decree has given one parent financial responsibility for the Child's health care, the plan of such parent pays first. The plan of the step-parent, if any, married to the parent with financial responsibility pays second. The plan of the other natural parent pays third.

   B. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the step-parent, if any, married to the parent with custody pays second. The plan of the parent without custody pays third.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) Employee, or as that person's Dependent pays first. The plan covering that person as a laid off or retired Employee, or as that person's Dependent pays second.

6. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

7. Dual TCSIG Plans
   If both spouses are employed by the same Employer or by separate participating Employers of TCSIG, and are covered as participants, these provisions will apply for all covered family members in the same manner as if the spouses were covered under two different plans.

8. Continuation of Coverage
   If a person is covered by another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for Pre-existing Conditions, the Other Plan shall be primary for all expenses which are not related to the limited Pre-existing Condition.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, all retired Covered Persons that are eligible for Medicare benefits, will be entitled to benefits under this Plan in addition to Medicare. However, any benefits of this Plan will be coordinated with Medicare. If any retired Covered Person is eligible for Medicare Parts A and B and fails to enroll, benefits will be paid as though he had enrolled.

To the extent required by Federal regulations, this Plan will pay Non-PPO Covered Expenses at the Reasonable and Allowable Amount before any Medicare benefits. There are circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under the Plan would be calculated as secondary payer. *The Covered Person will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Covered Person has enrolled for the full coverage*. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare allowable amount.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons who are covered under this Plan

If a Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this provision, TCSIG may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization or person any information with respect to any person. Any person claiming benefits under this Plan shall furnish to TCSIG such information as may be necessary to implement the Coordination of Benefits provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which would have been made under this Plan in accordance with this provision have been made under any Other Plan, TCSIG shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, TCSIG shall be fully discharged from liability under this Plan.

RIGHT TO RECOVERY

Whenever payments have been made by TCSIG with respect to Allowable Expenses in any amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, TCSIG shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as TCSIG shall determine: any individual to or for or with respect to whom such payments were made, any insurance companies, and any other organizations. TCSIG has the right to apply recovery to any additional benefits payable under this Plan.

SUBROGATION/THIRD PARTY LIABILITY

It is the intent of this Plan that any Covered Person will not be reimbursed for more than one hundred percent (100%) of his/her Allowable Expenses (as defined in the Coordination of Benefits provision). Therefore, the Plan maintains the right to seek reimbursement on its own behalf; the right of subrogation. The Plan also reserves the right to reimbursement upon a Covered Person's receipt of settlement, judgment or award; the right of third-party liability reimbursement.

When the Covered Person or covered Dependents, or anyone who received benefits under this Plan is injured and entitled to receive money from any source, including but not limited to any party's liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by this Plan are secondary, not primary. Any recovery will be deemed as compensation for medical expenses.

This provision allows the Plan to receive reimbursement for past, present and future medicals from the Covered Person or covered Dependents paid by any source resulting from the Accident or Injury. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency, without reduction for costs, comparative negligence, limits on collectability or responsibility, or otherwise. Reimbursement shall be made regardless of whether the Covered Person has been fully compensated, or "made whole" by their recovery.

The Plan will not pay any fees or costs unless expressly agreed to in writing and in advance, nor is it responsible for the Covered Person's court costs and attorney fees if the Plan needs to file suit to recover benefits paid on claims related to the third party Injury.

As a condition of receiving benefits under the Plan, the Covered Person agrees to the Plan's right to recovery under third party liability or subrogation rights against any third party up to the amount of expenses incurred by the Plan. Payment of benefits will be contingent upon the Covered Person's cooperation with the Claims Administrator by providing the Plan with all required information and assistance in the recovery of such payment or over-payment to the extent of such payment by this Plan. The term "information" includes any instruments and documents as TCSIG may reasonably require to enforce its rights.

The Plan shall pay up to one thousand dollars ($1,000.00) of Covered Expenses for any one incident involving a third party. Thereafter, the Covered Person must furnish the required information. Failure to provide the information shall result in denial of any additional related claims. Upon settlement, judgment or award, the Plan shall be reimbursed for all benefits paid including the first one thousand dollars ($1,000.00) paid on behalf of the Covered Person.

The Covered Person or Dependent will not take any action that would prejudice these reimbursement rights and will cooperate in doing whatever is reasonably necessary to assist in any recovery effort.

If the Covered Person takes no action to recover money from any source, then the Employee or Covered Person agrees to allow the Plan to initiate its own direct action for reimbursement.

TCSIG has delegated to the Claims Administrator and others the right to perform ministerial functions required to assert the Plan's rights, however, TCSIG shall retain discretionary authority with regard to asserting third party liability reimbursement and subrogation rights of the Plan.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

Tri-County Schools Insurance Group (TCSIG) is the Plan Administrator of this Plan. The Plan Administrator shall be in charge of and responsible for the operation and administration of this Plan.

The Plan Administrator is hereby designated the named fiduciary with respect to the administration of the Plan and the Trustee, if any, is designated as the named fiduciary with respect to the investment and management of the assets of the Plan. The Plan Administrator shall have the right from time to time to delegate to such persons or entities such Plan administration duties and responsibilities as the Plan Administrator deems appropriate. The Plan Administrator shall maintain such records as shall be necessary for the administration of the Plan. The Plan Administrator shall file all reports and documents which are required by law to be filed by the Plan Administrator. The Plan Administrator shall adopt and implement such procedures including, but not limited to, utilization review and case management procedures, as are deemed necessary in the sole discretion of the Plan Administrator to administer the Plan.

TCSIG has appointed a Claims Administrator to receive and initially review and process claims for Plan benefits. Any appeals of denied claims for Plan benefits shall be directed to the Claims Administrator for determination. TCSIG shall maintain complete authority for final review of all denied claims for benefits under the Plan including, but not limited to, the denial of certification of the medical necessity of Hospital or medical treatment. In exercising its fiduciary responsibilities, TCSIG shall have discretionary authority to determine whether and to what extent Covered Persons are entitled to benefits and to construe and interpret Plan provisions. TCSIG shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

ASSIGNMENT OF BENEFITS

Assignment of Benefits shall mean an arrangement whereby the Covered Person assigns their right to seek and receive payment of eligible Covered Expenses, in strict accordance with the terms of the Plan Document, to the Provider. If the Provider accepts the Assignment of Benefits, the Provider’s right to receive payment for Covered Expenses is equal to those of the Covered Person and is limited by the terms of this Plan Document. The Plan will only consider an Assignment of Benefits valid under the condition that Provider accepts the payment received from the Plan as consideration in full for the services, supplies and/or treatment rendered. By virtue of a valid Assignment of Benefits, the Provider will also have the right to appeal an Adverse Benefit Determination under the terms of the Plan Document. The Assignment of Benefits does not grant the Provider any other rights other than those specifically set forth in this Plan provision.

Note: By submitting a claim to the Claims Administrator and accepting payment by the Plan, the Provider is expressly agreeing to the Assignment of Benefits provision as well as the terms of the Plan Document. The Provider further agrees that the payments received constitute an “accord and satisfaction” and consideration in full for the services, supplies and/or treatment rendered and will take precedence over any previous terms and the patient will not be balance billed for any amount beyond the patient responsibility (Deductible/Coinsurance) that may be applicable.

If a Provider refuses to accept an Assignment of Benefits as consideration in full for the services rendered, the Reasonable and Allowable Amount payable under the terms of the Plan Document will be payable directly to the Covered Person and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense. In that event, the Covered Person will be responsible for all amounts that fall under the patient responsibility (Deductible/Coinsurance) as well as any amount that exceeds the Reasonable and Allowable Amount payable by the Plan.

The Assignment of Benefits does not grant the Provider the right to sue. The Assignment of Benefits accepted by a Provider only allows them to receive payment and to appeal an Adverse Benefit Determination.

The Covered Person may not, at any time, assign the Covered Person’s right to arbitration to recover benefits under the Plan or any other causes of action which the Covered Person may have against the Plan or its fiduciaries.

The Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.

BENEFITS NOT TRANSFERABLE

No person other than an eligible Covered Person is entitled to receive services and benefits under this Plan. Such right to services and benefits are not transferable.

CLERICAL ERROR

No clerical error on the part of the Employer, TCSIG or Claims Administrator shall operate to defeat any of the rights, privileges or services and benefits of any Employee or any Dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits shall be made when the error or delay is discovered, if appropriate at the sole discretion of TCSIG

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of the Plan which on its Effective Date is in conflict with federal or state statute(s), which apply to this Plan, is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The Effective Date of this Plan is July 1, 2005. Restated July 1, 2018.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any individual entitled to Hospital service and care hereunder to select a Hospital or to make a free choice of the attending Physician, who shall be the holder of a valid and unrevoked Physician's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the Hospital in which said Hospital services are to be provided and rendered. However, benefits will be paid in accordance with this Plan.

INCONTESTABILITY

All statements made by TCSIG, Employers or by the Employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing, signed by TCSIG

INDEPENDENT HEALTH CARE PROVIDERS

The Hospitals, Physicians, pharmacies, laboratories, and other health care Providers furnishing care to the Covered Person do so as independent Providers of service. Neither TCSIG nor the Employer shall be liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from a health care Provider.

Neither TCSIG nor the Employer shall be responsible for the furnishing of Hospital care, Skilled Nursing, Home Health Care, professional or medical services, nor for the quality thereof.

HEADINGS

The headings of the Plan are for reference only and shall not determine the interpretation or construction of this Plan.

LIABILITY IN EXCESS OF BENEFITS

Liability hereunder is limited to the services and benefits specified and TCSIG shall not be liable for any obligation of the Covered Person incurred in excess thereof.

MEDICAL NECESSITY

The benefits of this Plan are provided only for services that are Medically Necessary. The services and supplies must be ordered by the attending Physician for the direct care and treatment of a covered Illness or Injury, except for routine care as specifically stated herein. The services and supplies must be standard medical practice for the Illness or Injury being treated and must be legal in the United States. When an Inpatient Confinement is necessary, services are limited to those which could not have been performed on an Outpatient basis. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, in and of itself, make the service or supply Medically Necessary.

NONDISCRIMINATION

In the administration of this Plan, TCSIG shall act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Claims Administrator shall be entitled to rely on any such action, without being obliged to inquire into the circumstances.

NO VESTING

The benefits provided under this Plan to Covered Persons are neither guaranteed nor vested benefits.

PATIENT ADVOCACY CENTER

It is the position of the Plan that the Provider should not balance-bill the Covered Person for Non-PPO amounts in excess of the Reasonable and Allowable Amount. It is the position of the Plan that these Excess Charges are clearly excessive and exorbitant. However, balance-billing for such amounts can occur and the Plan has no control over the actions of the Providers or their desire to bill you for such amounts.

In the event you receive a balance-bill for an amount in excess of the Reasonable and Allowable Amount payable and would like advocacy services, email: patientadvocacy@hstechnology.com, or call the Patient Advocacy Center toll free at (888) 837-2237.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between TCSIG, Employers and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of TCSIG or the Employer, or to interfere with the right of TCSIG or the Employer to terminate the employment of any Employee at any time.

PLAN MODIFICATION AND AMENDMENT

TCSIG may modify or amend the Plan from time to time with proper advance notification, at its sole discretion and such amendments or modifications shall be evidenced by a written instrument signed by TCSIG. Any Plan changes which affect Covered Persons shall be communicated to the Covered Persons through their Employer.

PLAN TERMINATION

TCSIG may terminate the Plan at any time with proper notification. The Employer may terminate participation in the Plan in accordance with the TCSIG Joint Powers Agreement, Bylaws and policies. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan shall be communicated to the Covered Persons through their Employer.

PROTECTION OF COVERAGE

The Employer shall not have the right to cancel or terminate coverage of any individual Employee hereunder while this Plan remains in effect with the Employer and while said Employee remains eligible.

SECONDARY COVERAGE

To the extent required by Federal regulations, this Plan will pay Non-PPO Covered Expenses at the Reasonable and Allowable Amount before any Medicare benefits. There are circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under the Plan would be calculated as secondary payer. *The Covered Person will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Covered Person has enrolled for the full coverage.* If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare allowable amount.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons who are covered under this Plan
If a Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

SEVERABILITY

In the event that any provision of the Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) Daylight Savings Time or Standard Time as may be legally in effect at the address of TCSIG.

TERMS OF COVERAGE

In order for a person to be entitled to benefits under the Plan, both the Plan and the person's coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

The benefits to which a Covered Person may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date the Covered Person receives the service or supply for which the charge is made.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and begin with a capital letter throughout the document:

ACCIDENT:

Accident shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

ACCIDENTAL BODILY INJURY OR ACCIDENTAL INJURY

Accidental Bodily Injury or Accidental Injury shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

ACTIVELY AT WORK OR ACTIVE EMPLOYMENT:

Actively At Work or Active Employment shall mean on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively At Work on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not totally disabled, provided the covered Employee was Actively At Work on the last preceding regular work day. An Employee shall be deemed Actively At Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions. An Employee will not be considered under any circumstances Actively At Work if he or she has effectively terminated employment.

ADA:

ADA shall mean the American Dental Association.

ADVERSE BENEFIT DETERMINATION:

Adverse Benefit Determination shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

AFFORDABLE CARE ACT (ACA):

The Affordable Care Act (ACA) means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

AHA:

AHA shall mean the American Hospital Association.

ALLOWABLE EXPENSE(S):

Any reasonable, necessary and customary Covered Expense incurred while covered under this Plan, however, Allowable Expense does not include any expense contained in the Exclusions section of this Plan or excluded in any other section of the Plan.

ALTERNATE RECIPIENT:

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

AMA:

AMA shall mean the American Medical Association.

AMBULATORY SURGICAL CENTER:

A specialized facility where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or where coverage of such facility is not mandated by law, meets all of the following requirements:

1. It is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing Surgical Procedures.

2. It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full-time to such supervision and permits a Surgical Procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital (as defined) in the area.

3. It requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist (M.D., D.O.) administer the anesthetics and remain present throughout the Surgical Procedure.

4. It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-rays, and laboratory examinations; and has available to handle foreseeable emergencies, trained personnel, and necessary equipment.

5. It provides the full-time services of one or more graduate registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

6. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require postoperative Confinement.

7. It maintains an adequate medical record for each patient, such record to contain an admitting Diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report and a discharge summary.

APPROVED CLINICAL TRIAL:

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out-of-Network benefits are otherwise provided under the Plan.

BENEFIT PERCENTAGE (Coinsurance)**:**

The percentage payable by the Plan for covered benefits that are provided under the Plan. The Benefit Percentage is applied to Allowable Covered Expenses after the Deductible has been met.

BIRTHING CENTER:

A facility that meets professionally recognized standards and all of the tests that follow:

1. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated Pregnancy.

2. It has: (a) at least two delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) Emergency equipment, trays and supplies for use in life threatening events.

3. It has a medical staff that: (a) is supervised full-time by a Physician; and (b) includes a registered Nurse at all times when patients are in the facility.

4. If it is not part of a Hospital, it has written agreement(s) with a local Hospital(s) and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.

5. It admits only patients who: (a) have undergone an educational program to prepare them for the birth; and (b) have records of adequate prenatal care.

6. It maintains a medical record for each patient.

7. It complies with all licensing and other legal requirements that apply.

8. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

CALENDAR YEAR:

A twelve (12) month period starting each January 1st at 12:00 a.m. (midnight) Standard time as may be in effect at the address of TCSIG and ending December 31st at 11:59 p.m.

CARDIAC CARE UNIT:

Cardiac Care Unit shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.

5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

CDC:

CDC shall mean Centers for Disease Control and Prevention.

CENTER(S) OF EXCELLENCE:

Center(s) of Excellence shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the Pre-Certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

CHEMICAL DEPENDENCY:

A physiological or psychological dependency, or both, on a chemical substance, alcohol, or other mind-altering Drugs. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the chemical substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered, or the user's social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

CHILD AND/OR CHILDREN:

Child and/or Children shall mean the Employee’s natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee’s physical custody in anticipation of adoption. “Child” shall also mean a covered Employee’s Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

CHIP:

CHIP refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA:

CHIPRA refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

CHIROPRACTIC CARE:

Chiropractic Care shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

CHRISTIAN SCIENCE NURSE:

A Christian Science Nurse who is listed in the issue of the Christian Science Journal in effect at the time treatment and services are rendered.

CHRISTIAN SCIENCE PRACTITIONER:

A Christian Science Practitioner who is listed in the issue of the Christian Science Journal in effect at the time treatment and services are rendered.

CHRISTIAN SCIENCE SANATORIUM:

A facility accredited by the Department of Care of the First Church of Christ Scientist in Boston, Massachusetts at the time treatment and services are rendered.

CLAIM DETERMINATION PERIOD:

Claim Determination Period shall mean each Calendar Year.

CLAIMS ADMINISTRATOR:

The firm contracted by TCSIG which is responsible for the processing of claims and other services deemed necessary for the operation of the Plan.

CLEAN CLAIM:

A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claim forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

CLOSE RELATIVE:

The Employee's spouse, Children, brothers, sisters or parents; or the Children, brothers, sisters or parents of the Employee's spouse.

CMS:

CMS shall mean Centers for Medicare and Medicaid Services.

COBRA:

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURACE (BENEFIT PERCENTAGE):

The percentage payable by the Plan for covered benefits that are provided under the Plan. The Benefit Percentage is applied to Allowable Covered Expenses after the Deductible has been met.

COMPLICATIONS OF PREGNANCY:

A disease, disorder or condition which is diagnosed as distinct from Pregnancy, but is adversely affected by or caused by Pregnancy. Some examples are:

1. Intra-abdominal Surgery (but not elective Cesarean Section).
2. Ectopic Pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning Sickness; or like conditions that are not medically termed as Complications of Pregnancy.

CONCURRENT REVIEW:

Concurrent Review occurs during the Covered Person's Hospital Confinement to determine if continued Inpatient care is Medically Necessary.

CONFINEMENT:

A continuous stay in a Hospital, Skilled Nursing Facility, Hospice facility or at home due to an Illness or Injury diagnosed by a Physician. Later stays shall be deemed part of the original Confinement unless there was either complete recovery during the interim from the Illness or Injury causing the initial stay, or unless the later stay results from a cause or causes unrelated to the Illness or Injury causing the initial stay.

COSMETIC SURGERY:

The surgical alteration of hard and soft tissue for the improvement of a person's appearance rather than the improvement or restoration of bodily functions.

COVERED EXPENSE(S):

Those Medically Necessary services, supplies, and/or treatment that are covered under the Plan. Covered Expense does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by an Ambulatory Surgical Center, Birthing Center, Home Health Care Agency, Hospice, Hospital, Practitioner, Physician, Rehabilitation Facility, Skilled Nursing Facility, Treatment Center, Urgent Care Facility or other health care Practitioner (collectively, “Provider”.) Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to the negligence of a Provider’s medical error are not considered Covered Expenses. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered no Reasonable and Allowed.

COVERED PERSON(S):

An eligible Employee or the Employee's eligible Dependent(s) who is (are) covered hereunder and any qualified beneficiary who has elected continuation of coverage. A Covered Person also includes an entity acting on the Employee's behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

CREDITABLE COVERAGE:

Coverage of an individual under any of the following:

1. A group health plan, including governmental plans and church plans.

2. Health insurance, either group or individual insurance, including COBRA continuation of coverage.

3. Part A or B of Title XVIII of the Social Security Act (Medicare).

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

5. Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their Dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of Public Health Service).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.

8. The Federal Employees Health Benefits Plan (FEHBP).

9. A public health plan as defined in HCFA regulations.

10. Any health benefit plan under Peace Corps Act §5(e).

CUSTODIAL CARE:

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, and supervision over medication which can normally be self-administered.

Room and Board and skilled nursing services are not, however, considered Custodial Care if:

1. Provided during Confinement in an Institution for which coverage is available under this Plan, and

2. Combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the individual's medical condition.

DEDUCTIBLE:

The accumulated amount of Allowable Covered Expenses incurred throughout the Calendar Year which the Covered Person must pay before any Benefit Percentage applies. However, certain covered benefits may be considered Preventive Care and paid first dollar. The Participant's ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

DENTIST:

Dentist shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

DEPENDENT(S):

Dependents shall be the legal spouse (by marriage or registered domestic partner) of the Employee (unless legally separated) and natural Children, step Children, adopted Children or Children placed under guardianship (ward) from birth to their twenty-sixth (26th) birthday.

For further definition of Dependents, refer to Eligibility.

DIAGNOSIS:

Diagnosis shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

DIAGNOSTIC SERVICE:

Diagnostic Service shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

DISEASE:

Disease shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

DRUG:

Drug shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed Drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

DURABLE MEDICAL EQUIPMENT:

Medical equipment which can withstand repeated use; is not disposable; is used to serve a medical purpose; is not useful to a person in the absence of an Illness or Injury; and is appropriate for use in the home.

EFFECTIVE DATE:

The date of this Plan, or the date the Employer adopts this Plan, or the date on which the Covered Person's coverage commences, whichever occurs last.

EMERGENCY:

The sudden onset of a medical condition where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the Covered Person's life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

EMERGENCY ADMISSION:

An Emergency Admission occurs when a Covered Person is admitted to the Hospital as an Inpatient due to an Emergency, as defined.

EMERGENCY MEDICAL CONDITION:

Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES:

Emergency Services shall mean, with respect to an Emergency Medical Condition, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

EMPLOYEE OR EMPLOYEE GROUP:

An Employee is a person directly involved in the regular business of and compensated for services by the Employer, who is regularly scheduled to work not less than twenty (20) hours per work week, or is a contracted certified (academic) Employee with a fifty percent (50%) or greater full-time equivalent workload.

An Employee Group is any group defined under existing applicable collective bargaining law. The elected officials (e.g., Board), superintendent, management Employees, confidential Employees, classified Employees, certified (academic) Employees and Retirees will always be considered individual Employee Groups even when an Employer has no organized bargaining groups.

For the purpose of this document, the term "Employee" shall include all eligible Retirees, Retired elected officials, Employees under continuation of coverage, and Employee Groups.

EMPLOYER:

Agencies, as defined in the TCSIG Joint Powers Agreement and Bylaws, who have elected to participate in this Plan.

ENROLLMENT DATE:

The earliest of (1) the date of application for enrollment, or (2) the beginning of the waiting period for coverage.

EXPLANATION OF BENEFITS (EOB):

Explanation of Benefits shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

ESSENTIAL HEALTH BENEFITS:

Essential Health Benefits shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse Disorder services, including behavioral health treatment; prescription Drugs; Rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXCESS CHARGES:

The part of an expense for services, supplies and/or treatment of a covered Injury or Illness that is in excess of the Reasonable and Allowable Amount.

EXCLUSION:

Exclusion shall mean conditions or services that this Plan does not cover.

EXPERIMENTAL PROCEDURES:

Experimental Procedures are (1) those that have not yet been used frequently enough to establish a track record; (2) procedures that have not yet achieved a success rate high enough to be considered safe or efficient; (3) procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective by the Health Care Financing Administration.

FAMILY DEDUCTIBLE:

The accumulated amount of Covered Expenses incurred throughout the Calendar Year which the covered family must pay before any Benefit Percentage applies.

FAMILY UNIT:

Family Unit shall mean the Employee and his or her Dependents covered under the Plan.

FDA:

FDA shall mean Food and Drug Administration.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION:

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA:

FMLA shall mean the Family and Medical Leave Act of 1993, as amended.

FMLA LEAVE:

FMLA Leave shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

GINA:

GINA shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

HABILITATION/HABILITATIVE SERVICES:

Health care services that help a person keep, learn or improve skills and functioning for daily living which may include physical therapy, occupational therapy, and speech language pathology. These services when provided for autism spectrum disorder are not a covered benefit.

HEALTH SAVINGS ACCOUNT (HSA)

"Health Savings Account (HSA)" shall mean an account created as part of a High Deductible Health Plan. The money placed in this account can be used to pay for covered health care costs or saved for future health care costs. The account grows interest.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP):

"High Deductible Health Plan" shall mean a health plan which has to meet federal rules. This is so Participants can put money into a Health Savings Account or health reimbursement arrangement to help pay for health care. The plan Deductible is higher than a standard health plan.

HIPAA:

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH AIDE SERVICES:

Those services which may be provided by an individual, other than a registered Nurse, which are Medically Necessary for the proper care and treatment of an individual and are provided at home.

HOME HEALTH CARE:

A Home Health Care Agency program for continued care and treatment of the family member established and approved in writing by such Covered Person's attending Physician which begins within seven (7) days following termination of a Hospital Confinement or Skilled Nursing Facility Confinement as a resident Inpatient and is for the same or related condition for which the Covered Person was confined. The attending Physician must certify that the proper treatment of the Illness or Injury would require continued Confinement as a resident Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the Home Health Care plan.

HOME HEALTH CARE AGENCY:

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one graduate registered Nurse. It must provide for full-time supervision of such services by a Physician or graduate registered Nurse.

3. It maintains a complete medical record on each patient.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under Medicare.

HOSPICE:

An agency that provides counseling and medical services and may provide Room and Board to a terminally ill patient and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a Physician.

4. It has a Nurse coordinator who is a registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of Hospice services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the patient.

9. It is licensed if licensing is required.

HOSPITAL:

An Institution which is engaged primarily in providing medical care and treatment of Illness and Injury on an Inpatient basis at the patient's expense and which fully meets all the tests set forth in 1, 2, and 3 below:

1. It is an Institution which is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations.

2. It is an Institution qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

3. It is an Institution which fully meets the following criteria: (a) operates lawfully in the jurisdiction where it is located, and (b) maintains on the premises diagnostic and therapeutic facilities for surgical and medical Diagnosis and treatment of Illness or Injury by or under the supervision of a staff of duly qualified Physicians and continuously provides on the premises twenty-four (24) hours-per-day nursing service by or under the supervision of graduate registered nurses and maintains facilities for Surgery, except that the requirement of facilities for Surgery shall not apply to a mental Institution or other Institution operated primarily for the therapeutic treatment of the chronically ill.

Hospital shall also include a facility providing treatment for Chemical Dependency which operates lawfully and/or is accredited as an alcoholic treatment or Drug abuse facility by the Joint Commission on the Accreditation of Health Care Organizations.

Hospital shall also include Birthing Centers which are either a part of a Hospital or are "freestanding" as defined herein.

Hospital shall not include such facilities as a convalescent, nursing or rest home, or a home for the aged; a facility providing custodial or educational care.

HRSA:

HRSA shall mean Health Resources and Services Administration.

ILLNESS:

A bodily disorder, disease, physical Sickness, or Pregnancy of an eligible Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

IMPREGNATION AND INFERTILITY TREATMENT:

Impregnation and Infertility Treatment shall mean any services, supplies or Drugs related to the treatment of infertility.

INCURRED DATE:

With respect to a Covered Expense, the date the services or supplies are rendered.

INJURY:

A physical harm or disability which is the result of a specific unexpected incident caused by an external force. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a wound.

INPATIENT:

A Covered Person confined in a Hospital, Skilled Nursing Facility, or Hospice as a registered bed patient and charges are made for Room and Board to the Covered Person as a result of admission.

INSTITUTION:

Institution shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative Birthing Center, or any other such facility that the Plan approves.

INTENSIVE CARE:

A service which is reserved for critically and seriously ill patients requiring constant audio-visual surveillance which is prescribed by the attending Physician. Additionally provides Room and Board, and care by graduate registered nurses or other highly trained Hospital personnel utilizing special equipment and supplies immediately available on a standby basis. Services are rendered at a location segregated from the rest of the Hospital's facilities. This term does not include care in a surgical recovery room.

INTENSIVE OUTPATIENT SERVICES:

Intensive Outpatient Services shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/Rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial Rehabilitation,” and some “day treatment.”

LEAVE OF ABSENCE:

A period of time during which the Employee does not work, but which is of a stated duration after which time the Employee is expected to return to active work. If an Employee is on an approved Leave of Absence, he should contact his Employer for information regarding his right to continue coverage during such period.

MAXIMUM BENEFIT:

Any one of the following, or any combination of the following:

1. The maximum amount paid under any T.C.S.I.G Plan for any one Covered Person during the entire time he is covered by any TCSIG Plan.

2. The maximum amount paid by any TCSIG Plan for any one Covered Person for a specific Covered Expense. This maximum amount can be for:

   A. The entire time the Covered Person is covered under any TCSIG Plan, or

   B. A specified period of time, such as Calendar Year.

3. The "maximum number" the Plan acknowledges as a Covered Expense. The maximum number relates to the number of:

   A. Treatments during a specified period of time, or

   B. Days of Confinement.

   C. Visits by a Home Health Care Agency.

MEDICAL CHILD SUPPORT ORDER:

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

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

MEDICALLY NECESSARY:

A health care service, supply or treatment which is appropriate and consistent with the diagnosis and which, in accordance with usually accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

A service, supply or treatment will not be considered Medically Necessary if: (1) it is provided only as a convenience to the Covered Person or Provider; (2) it is part of a plan of treatment that is Experimental, unproven or related to a research protocol. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, in and of itself, make the service or supply Medically Necessary.

MEDICARE:

Medicare shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

MENTAL HEALTH DISORDERS:

Mental Health Disorder refers to a behavioral disturbance with no demonstrable organic or physical basis. Conditions affect the mental state of an individual; or cause nervous disorders and specified psychological dysfunctions; such as: disorders of infancy, childhood and adolescence, cognitive disorders, mental disorders caused by general medical conditions, substance-related disorders, schizophrenic and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, factitious disorders, eating disorders, sleep disorders, impulse-control disorders, adjustment disorders and personality disorders.

NATIONAL MEDICAL SUPPORT NOTICE OR NMSN:

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

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

NEGOTIATED RATE:

The rate Network Providers or PPOs have contracted to accept as payment in full for Covered Expenses of the Plan.

NETWORK:

As used in this Plan, the term Network may refer to any of the following:

1. The contracted medical service Providers.

2. The contracted Providers of service for managed psychiatric health care and Chemical Dependency services, or

3. The contracted pharmacies.

4. The contracted chiropractic Network

5. The contracted acupuncture Network

Network Providers agree to accept the Negotiated Rate as payment in full.

NO-FAULT AUTO INSURANCE:

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

NON-NETWORK:

Any psychiatric health care Provider or Chemical Dependency treatment Provider who is not contracted with the managed psychiatric health care and Chemical Dependency Network, any pharmacy not contracted with the pharmaceutical Network to provide reduced rates, or any chiropractic Provider not contracted with the chiropractic Network.

NON-PPO DEDUCTIBLE:

The accumulated amount of Covered Expenses incurred throughout the Calendar Year for services and supplies rendered by a Non-PPO which the Covered Person must pay before any Benefit Percentage applies to Non-PPO services and supplies.

NON-PREFERRED PROVIDER (NON-PPO):

A Physician, Hospital, or other health care Provider which does not have an agreement in effect with the Preferred Provider Organization (PPO) at the time services are rendered.

NURSE:

Nurse shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

ONE PERIOD OF CONFINEMENT:

All periods of Confinement regardless of cause or causes unless they are separated by a return to active work for an Employee or by a period of twenty-eight (28) days. However, if readmission to a Hospital is necessary as a result of Injury that Confinement will be considered a new period of Confinement for that Injury.

OPEN ENROLLMENT PERIOD:

Open Enrollment Period shall mean the time frame specified by the Plan Administrator.

OTHER PLAN:

Other Plan shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

OUT-OF-POCKET:

Expenses incurred by the Covered Person for their portion of Covered Expenses, including any Deductible, subject to limitations as specified in Medical Expense Benefit.

OUTPATIENT:

A Covered Person shall be considered to be an "Outpatient" if treated at (1) a Hospital as other than a registered bed patient, (2) Physician's office or (3) an Ambulatory Surgical Center; and Confinement is less than eighteen (18) consecutive hours.

OUTPATIENT SURGERY:

Elective (non-Emergency) Surgery performed in a surgical facility other than Confinement in a Hospital as a registered bed patient.

PARTIAL HOSPITALIZATION:

Partial Hospitalization shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

PARTICIPANT:

Participant shall mean any Employee, Dependent, Retiree, active elected officials and retired elected officials who are eligible for benefits (and enrolled) under the Plan.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA):

The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

PHYSICIAN:

1. A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or

2. One of the following Providers, but only when the Provider is licensed to practice where the care is provided, who is rendering a service within the scope of that license, and is providing a service for which benefits are specified in this Plan and when benefits would be payable if the services were provided by a Physician as defined in (1) above:

   A. A Dentist (D.D.S.) (D.M.D.)

   B. An optometrist (O.D.)

   C. A dispensing optician

   D. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

   E. A psychologist (Ph.D.)

   F. A chiropractor (D.C.)

The Physician may not be a Close Relative of the Covered Person.

PHYSICIAN VISIT:

A personal interview between the patient and a Physician and does not include telephone calls or interviews in which the Physician does not see the patient for treatment.

PLAN:

"Plan" refers to the benefits and provisions for payment of same as described herein, otherwise known as Consumer Driven Health Plan.

PLAN ADMINISTRATOR:

The Plan Administrator is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to perform services for the Plan, such as, process claims and perform other Plan connected services. The Plan Administrator is Tri-County Schools Insurance Group (TCSIG).

PLAN YEAR:

Plan Year shall mean July through June.

PRACTITIONER:

A Physician or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetists (C.R.N.A.), Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Registered Physical Therapist (P.T. or R.P.T.), Licensed Acupuncturist, Physician's Assistant, Registered or Certified Respiratory Therapist, Occupational Therapist, Speech Therapist, Speech Pathologist, Masters prepared Social Worker (M.S.W.), a Clinical Social Worker (C.S.W. or L.C.S.W.), a Marriage, Family and Child Counselor (M.F.C.C.), Marriage Family Therapist (M.F.T.), Christian Science Practitioner, or Nurse Practitioner.

PRE-ADMISSION TESTING:

Testing prescribed by a Physician in connection with a planned Hospital Confinement or Outpatient Surgery. The testing must be:

1. Performed in a covered facility on an Outpatient basis;
2. Necessary to diagnose and treat the condition for which Confinement is planned; and
3. Performed within seven (7) days prior to a Hospital Confinement or Outpatient Surgery.

PRE-CERTIFICATION:

Certification of medical necessity by the Utilization Review Organization (URO) or the managed psychiatric health care and Chemical Dependency Network or Chiropractic Network.

PREFERRED PROVIDER:

The contracted Physicians, Hospitals or other health care Providers who have an agreement in effect with the Preferred Provider Organization (PPO) at the time services are rendered. Preferred Providers agree to accept the Negotiated Rate as payment in full.

PREFERRED PROVIDER ORGANIZATION (PPO):

An organization which selects and contracts with certain Hospitals, Physicians, and other health care Providers to provide Covered Persons services, supplies, and treatment at a Negotiated Rate.

PREGNANCY:

The physical state which results in childbirth or miscarriage and any medical complication arising out of, or resulting from, such state.

PREVENTIVE CARE:

Preventive Care shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:
https://www.hrsa.gov/womensguidelines/
https://www.cdc.gov/vaccines/schedules/easy-to-read/index.html
https://www.uspreventiveservicestaskforce.org

For more information, Participants may contact the Plan Administrator / Employer.

PRIOR COVERAGE OR PRIOR PLAN:

Any plan of group Accident and health benefits provided by the Employer (or its predecessor) for an entire Employee Group or Employer which has been replaced by coverage under this Plan.

PROVIDER:

Provider shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant Provider type.

QUALIFIED MEDICAL CHILD SUPPORT ORDER OR QMCSO:

Qualified Medical Child Support Order or QMCSO shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

REASONABLE AND ALLOWED:

The maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount is the *lesser of*:

1. The charge made by the Provider that furnished the care, service or supply;
2. The negotiated amount established by discounting or negotiated arrangement;
3. The reasonable and customary charge for the same treatment, service or supply furnished in the same geographic area by a Provider of like service of similar training and experienced as further described below; or
4. An amount equivalent to the following:
    - For Inpatient or Outpatient facility claims, an amount equivalent to 140% of the Medicare equivalent allowable amount;
    - For Physician or other Provider claims, an amount equivalent to 120% of the Medicare equivalent allowable amount.

The reasonable and customary charge referenced above in #3 shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan from time to time. If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made.

For Covered Expenses rendered by a Physician, Hospital or other Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the amount established by the applicable law for the Covered Expense.

The Plan Administrator or its designee has the ***ultimate discretionary authority*** to determine the Reasonable and Allowed Amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowed Amount even if such negotiated terms do not satisfy the lesser of test described above.

REHABILITATION:

Rehabilitation shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

REHABILITATION FACILITY:

A facility designed exclusively for rehabilitative services where the Covered Person receives treatment as a result of catastrophic Illness or Injury.

RESIDENTIAL TREATMENT FACILITY:

Residential Treatment Facility shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, Drug or Substance Abuse disorders or mental illness.

RETIREE:

An Employee, as defined by the Employer's bargaining agreement(s) or policies, who is receiving pension benefits from the Public Employees' Retirement System (P.E.R.S.) or the State Teachers' Retirement System (S.T.R.S.) and who, on the date immediately prior to retirement, was covered by a TCSIG medical Plan.

RETROSPECTIVE REVIEW:

Retrospective Review occurs after the Covered Person's discharge to determine if, and to what extent, Inpatient care was Medically Necessary.

ROOM AND BOARD:

The Hospital's most common Semiprivate Room and Board charge for room and linen service; dietary service including meals, special diets and nourishments; and general nursing service.

SECOND SURGICAL OPINION:

A surgical consultation by a specialist who is not affiliated with the surgeon to confirm the medical advisability of proposed elective Surgery.

SEMIPRIVATE:

A class of accommodations in a Hospital or Skilled Nursing Facility in which at least two (2) patients' beds are available per room.

SERVICE WAITING PERIOD:

Service Waiting Period shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

SICKNESS:
Sickness shall have the meaning set forth in the definition of "Disease."

SKILLED NURSING FACILITY:

An Institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services rendered by a graduate registered Nurse or by a licensed practical Nurse under the direction of a graduate registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or graduate registered Nurse.

3. It provides twenty-four (24) hours-per-day nursing services by licensed nurses, under the direction of a full-time graduate registered Nurse.

4. It maintains a complete medical record on each patient.

5. It is not, other than incidentally, a place for rest, for the aged, Drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

6. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an Institution referring to itself as an Extended Care Facility, Convalescent Nursing Facility or any such other similar designation.

SUBSTANCE ABUSE AND/OR SUBSTANCE USE DISORDER:

Substance Abuse and/or Substance Use Disorder shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Craving or a strong desire or urge to use a substance.
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

SURGERY:

Surgery shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

SURGICAL PROCEDURE:

Surgical Procedure shall have the same meaning set forth in the definition of Surgery.

TOTAL DISABILITY (TOTALLY DISABLED):

The Employee is prevented from engaging in his regular, customary occupation or for an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit or; a Dependent is prevented from engaging in all of the normal activities of a person of like sex and age who is in good health.

TREATMENT CENTER:

An Institution which does not qualify as a Hospital, but which does provide a program of effective medical and therapeutic treatment for Chemical Dependency, and

1. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law.
2. Where coverage of such treatment is not mandated by law, meets all the following requirements:

   A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.

B. It provides a program of treatment approved by the Physician.

C. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Covered Person.

D. It provides at least the following basic services:

(1) Room and Board

(2) Evaluating and diagnosis

(3) Counseling

(4) Referral and orientation to specialized community resources

UNIFORMED SERVICES:

Uniformed Services shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

URGENT CARE FACILITY:

A freestanding facility which is engaged primarily in providing minor Emergency and episodic medical care to Covered Persons. A Physician, a graduate registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. However, a facility located on or in conjunction with or in any way made a part of a Hospital shall be excluded from the terms of this definition.

USERRA:

USERRA shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

UTILIZATION REVIEW ORGANIZATION (URO):

The firm contracted by TCSIG which is responsible for systematically reviewing for medical necessity, appropriateness of health care, appropriateness of Institution providing treatment, nature and scope of treatment and timeliness and appropriateness of discharge.

HIPAA Notice of Privacy Practices

Confidentiality of your health care information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Tri-County Schools Insurance Group (TCSIG) and its service partners protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's health care history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. TCSIG is the plan sponsor and receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited. Providing PHI to your employer is also prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health care information.

We may change this notice and make the new notice effective for your entire PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a TCSIG program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted uses and disclosures of your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. We may disclose PHI to third parties that perform services for TCSIG in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to a service partner that performs services for TCSIG in the administration of your benefits. These service partners have implemented privacy and security policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization from you, to notify or assist in notifying a family member, another person, or a personal representative of your condition. We are also permitted to use and/or disclose your PHI to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers' compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of uses and disclosures of your PHI for treatment, payment or health care operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment. *For example, TCSIG may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, TCSIG may use and disclose your PHI to pay claims for services provided to you.*
- Uses and/or disclosures of PHI for health care operations. *For example, TCSIG may use and disclose your PHI to engage in customer service and appeal services.*

Disclosures without an authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of the Department of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. TCSIG may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations

Disclosures TCSIG makes with your authorization

TCSIG will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by TCSIG or by a person requesting your PHI from TCSIG.

Your rights regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting the TCSIG office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. TCSIG may charge a reasonable fee for providing you copies of your PHI. TCSIG will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by TCSIG to the provider or third-party administrator after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that TCSIG does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the TCSIG office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI.

This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, and another method of contact or information as to how payment will be handled. Please make this request in writing to the TCSIG office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to six (6) years from the date of your request. Please contact the TCSIG office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail.

You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us at the TCSIG office or to the U. S. Secretary of the Department of Health and Human Services if you believe that TCSIG has violated your privacy rights. You may file a complaint with us by notifying the office as noted below. We will not retaliate against you for filing a complaint.

You may contact us at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Effective Date: July 1, 2018

Tri-County Schools Insurance Group (TCSIG)
Attn: Privacy Officer
1176 Live Oak Boulevard, Suite A Yuba City, CA 95991
(530) 822-5299 or (866) 822-5299