Plan Document and Summary Plan Description for the West Shore Educational Service District Health and Welfare Benefit Plan

- Your Health Care Benefits
- Your Health Reimbursement Arrangement (“HRA”)
- Your Health Savings Account (“HSA”)
- Your Life Insurance and AD&D Benefits
- Your Disability Benefits

EFFECTIVE DATE: 01/01/2019
Introduction

West Shore Educational Service District (the “Employer” or “Company”) is pleased to offer benefits through the Plan Document and Summary Plan Description for the West Shore Educational Service District Health and Welfare Benefit Plan. These benefits are a valuable and important part of your overall compensation package.

This booklet provides important information about the Benefit Program(s) covered under the Plan. It serves as the Plan document and the Summary Plan Description (“SPD”) for the Plan Document and Summary Plan Description for the West Shore Educational Service District Health and Welfare Benefit Plan (“the Plan”).

The “Benefit Programs” covered by this Plan are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs. This booklet is not intended to give any substantive rights to benefits that are not already provided by the insurance certificate for an insured benefit. If the terms of this booklet conflict with the substantive terms of an insurance certificate for an insured Benefit Program, the terms of the insurance certificate will control, unless otherwise required by law.

This Plan document/SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference. We encourage you to read this booklet and insurance certificates and become familiar with your benefits. You may also wish to share this information with your enrolled family members.
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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time actively-at-work employee normally scheduled to work a minimum of 30 or more hours per week or as dictated by the collective bargaining agreement(s). Part-time employees are eligible if they pay the entire premium cost.

Union employees are eligible for coverage if your benefits are covered under the terms of the collective bargaining agreement between the Employer and the:

ASFCME Council 25 Chapter 2389
West Shore Educational Service District Education Association

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Employer payroll, as determined by the Employer.

The Employer’s determination of eligibility is conclusive and binding for Plan purposes. No reclassification of a person’s status, for any reason, by a third party (whether by a court, governmental agency or otherwise) will change a person’s eligibility for benefits under the Plan.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
• your stepchild;
• a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
• a child for whom you are the court-appointed legal guardian;
• an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other’s coverage, but only one of you may cover your dependent children.

When Coverage Begins
To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins on the first day of employment.

Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will need to satisfy any eligibility requirements to be covered under the Plan.

Unless stated otherwise in your insurance certificates, coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage. If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan’s next open enrollment period to enroll your new dependent for coverage.

Look-back Measurement Method for Determining Full-time Employee Status
The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan’s health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:
• All employees

The look-back measurement method involves three different periods:
• Measurement period
• Stability period
• Administrative period
The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the “standard measurement period.” Your hours of service during the standard measurement period will determine your eligibility for the Plan’s health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the “initial measurement period.” Your hours of service during the initial measurement period will determine your eligibility for the Plan’s health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan’s health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

**Proof of Dependent Eligibility**

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan’s Benefit Programs. If you are asked to verify a dependent’s eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.
Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

Initial Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

The elections you make will remain in effect until the next December 31, unless a permitted election change event occurs (see below). Your insured benefits may have a different coverage period. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. After your initial enrollment, you will enroll during the designated annual open enrollment period.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. In general, the elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. Also, you should refer to the insurance certificate provided by the Insurer for more information on how your benefits are affected by the policy year, including whether your deductible and out-of-pocket expenses accumulate over the Plan Year, policy year or other 12-month period.

Special Enrollment Rights

You may enroll for coverage outside of the Plan's initial and annual open enrollment periods if you experience a special enrollment event, as described below. Special enrollment rights apply to the Plan's medical benefits. These rights, however, may not apply all Benefit Programs (for example, these rights do not apply to Benefit Programs that are “excepted benefits” under
HIPAA). You should review your insurance certificate and check with the Plan Administrator if you have questions about enrolling in a Benefit Program.

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.

- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

You will need to provide documentation of your special enrollment event in order to enroll outside of an initial or annual open enrollment period. Contact the Plan Administrator to determine what information you will need to provide.

**Code Section 125 Status of Plan**

This Plan is designed and administered in accordance with Section 125 of the Internal Revenue Code and underlying regulations. This enables you to pay your share of premiums for certain Benefit Programs on a pre-tax basis, as permitted by the Employer. Review your election and enrollment materials to determine which Benefit Programs permit pre-tax premium payments and are subject to the Section 125 rules. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld (and, in most states, before state taxes are withheld). This gives your contributions a special tax advantage and lowers the actual cost of participating in the Plan to you. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections for Section 125 benefits. Generally, your elections stay in effect for the Plan Year (or other 12-month period of coverage for an insured benefit, as designated in your enrollment materials and election form) and you can make changes only during an annual open enrollment period. However, depending on the Plan's rules for mid-year election change events, you may be able to change your elections if a permitted election change event occurs as described below.
Permitted Election Change Events

The elections you make under the Plan are generally irrevocable during the Plan Year (or other 12-month coverage period that applies to a Benefit Program, as indicated in your enrollment and election materials). This means, for example, that once you have elected how much pre-tax income you will use to pay for the Plan’s Benefit Programs, you are locked into that election until the next annual enrollment period. However, there are certain limited situations that allow you to change your Plan elections outside of the annual enrollment period, depending on the Plan’s eligibility rules for a Benefit Program. You may change your elections if a “permitted election change event” occurs and you make an election change that is consistent with the event, as determined by the Plan Administrator.

Only the following “permitted election change events” are recognized by the Plan:

- a change in your legal marital status, including marriage, divorce, death of spouse, legal separation or annulment
- a change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent
- a change in employment status for you, a spouse or a dependent that affects eligibility
- a change in a dependent child’s eligibility

The Plan Administrator may decide to recognize other election change events that are permitted by the IRS. Also, if the cost of a Benefit Program changes by an insignificant amount during a coverage period, the Plan Administrator may automatically make a corresponding change to your election. You should report an election change event to the Plan Administrator as soon as possible, but no later than 30 days after the event occurs. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends at the end of the month in which the employee is terminated. Coverage may be extended under certain circumstances, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer’s termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.
Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan’s claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as “excepted benefits” under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer’s FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.
Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. Any restrictions for electing or declining coverage will be shown on your Election Form. You may also enroll your dependents if they are eligible dependents as defined in the Insurer’s benefits booklets.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost. You have the flexibility to choose providers inside or outside the network each time you need services.

The following type of medical program is available to you under the Plan: a PPO (Preferred Provider Organization).

Generally, when you use network providers, the Plan pays the negotiated amount of covered expenses (after any deductible) to your provider and there are no claim forms to complete. For example, under a PPO or CDHP network, you may receive care from any provider you choose with no referral required. However, if you choose a provider who participates in the Plan’s network, your costs will be lower since network providers have agreed to accept a negotiated rate as payment in full. If you receive care outside of the Plan’s network, benefits are based on reasonable and customary charges and, in most cases, you must pay your portion of the cost, plus any amount billed over the reasonable and customary limits. You may also be required to file claim forms for reimbursement. Your Certificate of Coverage and other documents provide additional information on how benefits are paid when you access in-network providers and out-of-network providers.

When you enroll in a Plan that uses a network of physicians, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist. For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown later in this booklet.

The following type(s) of dental plans or programs of benefits are included under this Plan:

- a DPPO (Dental Preferred Provider Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims.
Certain dental options, such as a DMO, may require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer for the dental care plan or program at the telephone number or website shown later in this booklet.

**Source of Payments**

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on a pre-tax basis.

**Opt-out Incentive**

There is an opt-out incentive available for eligible employees who waive health care coverage under the Plan. For more information on this incentive, including the eligibility rules, amount of incentive and payment terms, see your enrollment materials or contact the Plan Administrator.

**Limitations and Exclusions**

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

**Continuation of Health Care Coverage through COBRA**

If your health care coverage under the Plan ends for reasons other than the Employer’s termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). Health care coverage may continue at your own expense for a specific length of time. See the section entitled “Your HIPAA/COBRA Rights” for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

**For More Information**

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.
Your Health Reimbursement Arrangement (“HRA”)

An HRA is an arrangement funded entirely by the Employer. The purpose of the HRA is to reimburse you, up to certain limits, for you and your covered dependents’ eligible out-of-pocket health care expenses, as explained below. Reimbursements paid by the HRA generally are excluded from taxable income.

How the HRA Works

Once you enroll in coverage, the Employer will establish an “HRA Account” in your name to keep a record of the amounts available to you for reimbursement of eligible health care expenses. This account is merely a recordkeeping account; it is not funded nor does it accrue earnings or interest of any kind. Reimbursements are made from the general assets of the Employer.

Before the start of each Plan Year, the Employer will determine the amount that may be credited during that Plan Year to your HRA. This amount will be shown in your enrollment materials. You do not contribute any money to the HRA.

The total annual Employer contribution amount will be credited to your HRA Account on your first day of coverage. If you first enroll in coverage during annual enrollment, your HRA funds will be available for reimbursement the first day of the next Plan Year.

Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible health care expenses. The amount available for reimbursement as of any given date will be the total amount credited to your HRA as of such date, reduced by any prior reimbursements made to you. You may submit eligible expenses that you incur during a coverage period. Expenses are incurred when the service is performed or received.

Generally, your HRA can be used for the same expenses that qualify as a medical deduction on your Federal tax return. These are typically expenses related to the diagnosis, care, treatment, or prevention of disease. Expenses also include your deductible, coinsurance, copayments, and other out-of-pocket expenses not covered under any health care plan. A complete list of qualified medical expenses may be found in IRS Publication 502, available at www.medicare.gov or www.irs.gov.

You receive a new Employer contribution each year you remain a participant in the HRA option. Any unreimbursed amount will be forfeited at the end of the coverage period.

You have the opportunity to opt out of and waive future reimbursements from the HRA at least annually. Contact your Employer for more information on opting out of the HRA.

How to Use Your HRA

When you incur eligible medical expenses during a coverage period, reimbursement may be made from your available HRA balance. There are a few possible reimbursement methods for HRAs. The methods that are available to you depend on how the HRA is administered. These methods may include, for example, having participants submit their own reimbursement requests to the Claims Administrator after eligible medical expenses are incurred, allowing participants to use an HRA debit card with qualified providers or using an automatic claims submission process. Not all of these reimbursement methods may be available to you. When you are enrolled in the HRA, your Employer will provide you with more specific information on how your HRA reimburses eligible medical expenses.
Your HRA can only be used to reimburse eligible medical expenses incurred by you (or your eligible dependents, if applicable). In some circumstances, the Claims Administrator may ask you to provide additional documentation to show that a medical expense is eligible for reimbursement. If you do not provide this information or if the Claims Administrator otherwise determines a reimbursement was improper, the Claims Administrator may take steps to correct the improper payment (including, for example, asking you to repay the full amount of the improper payment or deducting the improper payment from future HRA reimbursements).

**Maintaining Records**

You should keep all receipts to document expenses reimbursed to you from the HRA. If a payment must be verified at a later date, the Claims Administrator may request receipts from you to ensure that payment was made for a qualified expense. If a claim for benefits is denied, you have the right to appeal (see “Claims Procedure” for additional information) with the Claims Administrator.

**When Participation Ends**

Your participation in the HRA ends when you terminate employment. You may continue to access your HRA balance as described below.

If you terminate employment, your available HRA balance can be used only for eligible expenses incurred before the date of your termination. Any remaining amounts will be forfeited.

If your Employer is covered by COBRA and your health coverage ends due to a COBRA qualifying event, you will be given the opportunity to enroll in COBRA continuation coverage and elect an HRA medical option. If you elect COBRA for an HRA medical option, you can continue to use your remaining HRA balance to pay for eligible expenses and you will be eligible for the HRA accruals that similarly situated non-COBRA participants receive during your period of COBRA coverage. When you enroll in COBRA, your COBRA premium will include an amount to continue your HRA. You will be provided with more information on your COBRA coverage options if you experience a qualifying event.

**For More Information**

For additional information about your HRA, contact the Claims Administrator or refer to your enrollment materials.
Your Life and Accidental Death & Dismemberment ("AD&D") Coverage

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- Voluntary Life Insurance (supplemental and/or dependent life)
- AD&D Insurance
- Voluntary AD&D Insurance (supplemental and/or dependent AD&D)

Participation

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic. Any voluntary options available to you and the associated costs are described in the materials provided by the Insurer. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your voluntary coverage, or confirm that your existing coverage is to be maintained for the following year.

Benefits Provided

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions. The amounts of voluntary coverage available and, if applicable, any premiums for coverage will be shown on your Election Form when you enroll and will automatically be deducted from your pay.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.
Your Disability Benefits

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Voluntary Short-Term Disability (STD) Benefits – Employee paid
- Long-Term Disability (LTD) Benefits – Employer paid
- Voluntary Long-Term Disability (LTD) Benefits – Employee paid

Participation

If you wish to elect voluntary STD coverage, you must enroll in coverage after you meet all eligibility requirements. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary STD coverage will be shown on your Election Form when you first enroll in the Plan.

Your LTD coverage begins after you satisfy all eligibility requirements for coverage. Enrollment is automatic - no action is required on your part other than completing an application where required. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable.

If you wish to elect voluntary LTD coverage, you must enroll in coverage after satisfying all eligibility requirements for coverage. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary LTD coverage will be shown on your Election Form.

Benefits Provided

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

Your Certificate of Insurance also describes the actual benefit you are eligible to receive when you become disabled and its duration.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

Source of Payment

All disability benefits described above are paid by the Insurer and are guaranteed under the applicable insurance contract(s) or policies.

Payment of Benefits

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.
Offset of Other Benefits
If you become eligible for any disability benefits under state law or disability fund, Workers’ Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

Limitations and Exclusions
No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.
You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

Claims and Appeals
If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

For More Information
Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.
Your Health Savings Account (“HSA”)

Your medical coverage may enable you to establish an HSA. To be eligible for an HSA, you must:

- Be covered by a high deductible health plan (“HDHP”);
- Not be covered by other health coverage that is not an HDHP (with some limited exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person’s tax return.

To establish an HSA, you will need to open an account at an approved financial institution which will be used to pay for current and future health care expenses. Anyone can contribute to your HSA on your behalf, including a family member, your Employer or yourself.

How Your HSA Works

An HSA works in conjunction with an HDHP. Your HDHP will cover your eligible health care expenses after you meet your deductible. You can use your HSA to pay for eligible medical expenses until you meet your HDHP’s deductible, or you can use your HSA to pay for qualified medical expenses not covered under your HDHP (for example, dental or vision expenses).

The HSA is not a part of the HDHP and is not sponsored by your Employer. The information in this section is provided only as an overview of the HSA benefit.

Your HSA can provide a triple tax advantage—contributions, investment earnings and amounts distributed for qualified medical expenses are all exempt from Federal tax and most state income taxes.

HSA Contributions

After you open your account, you (or anyone else on your behalf) can make contributions to your HSA. Unless indicated otherwise in your enrollment materials, you can make your HSA contributions by personal check and then deduct your contributions on your Federal income tax return. If you are allowed to make pre-tax salary reduction contributions to your HSA, that information will be included in your enrollment materials.

Your Employer may contribute an annual amount (as shown in your enrollment materials) to your HSA. This amount may be a flat dollar amount payable to all participants or it may be based on the coverage you select (for example, self-only or family coverage). Employers are not required to make HSA contributions. If your enrollment materials do not show an Employer contribution, this means that your Employer does not contribute toward your HSA.

Because of an HSA’s powerful tax savings, there are strict limits on how much can be contributed to your HSA each year. The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual and the date you cease to be an eligible individual. All contributions to your HSA for a calendar year (including contributions you, your Employer or anyone else makes on your behalf) are counted toward the HSA contribution limit.

In addition, if you are age 55 or older, you are permitted to make a $1,000 “catch-up” contribution to your HSA each year.
You may wish to discuss your individual tax situation with your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans, available at www.irs.gov.

**Using Your HSA**

You can receive tax-free distributions from your HSA to pay (or be reimbursed) for qualified medical expenses you incur after you establish your HSA. You can use your HSA account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for yourself and your eligible dependents. A list of qualified medical expenses may be found in IRS Publication 502, available at www.irs.gov.

You will receive information about how to use your HSA when you open your account. Depending on where your account is, you may be issued a debit card or checkbook to pay for eligible expenses. It is important for you to keep receipts in order to document expenses for any tax year that may come under review.

You do not have to make distributions from your HSA each year. Unlike some other types of medical savings accounts, your HSA account balance rolls over from year to year.

If you use the money in your HSA for non-qualified medical expenses, the amount is subject to ordinary income tax, plus a 20-percent tax penalty if you are under age 65. The tax penalty generally does not apply if the distribution occurs after you reach age 65, become disabled or die; however, ordinary income tax will still apply.

**Important Information about your HDHP/HSA**

Participation in an HDHP/HSA is subject to the following IRS requirements:

- Your medical and prescription drug expenses are combined toward meeting your deductible—there is not a separate deductible for prescription drug expenses. This means that you have to pay the full cost for prescriptions, as well as medical expenses, until you have paid the HDHP's applicable deductible amount (individual or family). Then, the plan starts to pay. However, your HDHP may provide preventive care benefits without a deductible.

- You cannot be enrolled in other medical coverage (including a plan through your spouse's employer) that is not an HDHP, even as a dependent. However, you can participate in certain permissible types of coverage, such as a limited-purpose HRA or health FSA that reimburses or pays for dental and vision expenses.

- You cannot be enrolled under your spouse's non-HDHP coverage. However, you can still be an eligible individual even if your spouse has non-HDHP coverage, provided you are not covered by that plan.

- You cannot be enrolled in Medicare coverage.

For additional information about how an HDHP/HSA works, refer to IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans.

**When Your HDHP Participation Ends**

Your HSA belongs to you. It stays with you when you change employers or leave the workforce. If your medical coverage under the Plan terminates for any reason, the funds in your HSA account remain yours. Your HSA is also inheritable. What happens to your HSA when you die
depends on who you name as your beneficiary. You will need to designate a beneficiary when you open your HSA.

You can make tax-free contributions to your HSA if you participate in another HDHP (and meet the other requirements for HSA eligibility). You may continue to use your HSA to pay for qualified medical expenses, or you may elect to leave the money in your account grow on a tax-free basis to use for future health care expenses. However, once you enroll in Medicare or are no longer covered by an HDHP, you are not permitted to make contributions to your HSA.

You may use your HSA funds to pay Medicare premiums. Payment of Medicare premiums is a qualified expense and a tax-free distribution. If you are 65 or older, HSA distributions used for non-qualified medical expenses will be subject to ordinary income tax but exempt from the additional penalty tax.

**Additional Information**

For additional information about your HSA, contact the financial institution where your account is established. Since the rules governing HSAs are complex, you may also wish to obtain a copy of IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.
Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights Federal laws such as COBRA.

IMPORTANT: This Summary Plan Description may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

West Shore Educational Service District is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator
West Shore Educational Service District
2130 W. US Highway 10
Ludington, MI 49431
231-898-1559

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.
For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

**Plan Year**
The Plan Year is January 1 through December 31.
Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine how the policy year impacts your benefits.

**Type of Plan**
This Plan is a called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

**Identification Numbers**
The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 38-1722100     PLAN NUMBER: 501

**Plan Funding and Type of Administration**
Funding and administration of the Plan is as follows.

<table>
<thead>
<tr>
<th>Type of Administration</th>
<th>The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.</td>
</tr>
</tbody>
</table>

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.
If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.
**Insurers/Claims Administrators**

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

It is important to understand that if the terms of this SPD conflict with the terms of the insurance certificate regarding substantive rules for an insured Benefit Program (such as benefits and claims procedures), the terms of the insurance certificate will control, unless otherwise required by law.

**Medical/Prescription Drug Benefits**

MESSA  
1475 Kendale Blvd.  
P.O. Box 2560  
East Lansing, MI 48826  
517-332-2581  
www.messa.org

Blue Cross Blue Shield of Michigan  
600 E. Lafayette Blvd.  
Detroit, MI 48226  
877-790-2583  
www.bsbsm.com

**Vision Benefits**

MESSA  
1475 Kendale Blvd.  
P.O. Box 2560  
East Lansing, MI 48826  
517-332-2581  
www.messa.org

VSP  
3333 Quality Drive  
Rancho Cordova, CA 95670  
800-877-7195  
https://www.vsp.com/

**Group Term Life Insurance Benefits**

MESSA  
1475 Kendale Blvd.  
P.O. Box 2560  
East Lansing, MI 48826  
517-332-2581  
www.messa.org

Cigna
900 Cottage Grove Road
Bloomfield, CT 06002
800-997-1654
www.cigna.com/

**Accidental Death & Dismemberment Benefits**

MESSA
1475 Kendale Blvd.
P.O. Box 2560
East Lansing, MI 48826
517-332-2581
www.messa.org

Cigna
900 Cottage Grove Road
Bloomfield, CT 06002
800-997-1654
www.cigna.com/

**LTD Benefits**

MESSA
1475 Kendale Blvd.
P.O. Box 2560
East Lansing, MI 48826
517-332-2581
www.messa.org

Cigna
900 Cottage Grove Road
Bloomfield, CT 06002
800-997-1654
www.cigna.com/

**Agent for Service of Legal Process**

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

West Shore Educational Service District
2130 W. US Highway 10
Ludington, MI 49431
231-898-1559

Service of Legal Process may also be served on the Plan Administrator.

**No Obligation to Continue Employment**

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer’s right to terminate your employment, with or without cause.
Severability
If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others
The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses
All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud
No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity
To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates
Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), the Women’s Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle’s Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions
For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants’ portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after
weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

**Nondiscrimination**

The Plan is intended to be nondiscriminatory under Code Section 125. Code Section 125 prohibits discrimination in favor of highly compensated individuals with respect to eligibility to participate, highly compensated participants with respect to benefits and contributions and key employees with respect to total Plan contributions. If the Plan Administrator determines, at any time, that the Plan may fail to satisfy these nondiscrimination requirements, the Plan Administrator may take such action as it deems appropriate to comply with the nondiscrimination requirements. This action may include, for example, modifying the elections of highly compensated or key employees without their consent.

**No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any representation, guarantee or warranty that any amount paid as premiums or distributed as benefits under the Plan will be excludable from your gross income for federal or state income tax purposes (or that any other state or federal tax treatment will apply or be available to you). It is your responsibility to determine whether payments are excludable from your gross income for federal and state income tax purposes.

**Future of the Plan**

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.
Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. A rescission of coverage is also considered an adverse benefit determination that triggers your right to file an appeal. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer’s decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program’s provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.
The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers’ plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

**Health Care Coverage Coordination with Medicare**

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first (“primary”) is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer’s plan to pay first and Medicare pays second (“secondary”). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer’s coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.

- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

**Subrogation and Reimbursement**

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.
Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.
Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child’s birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled
family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child’s loss of eligible dependent status under this Plan.

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child’s loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To
continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

*NOTE:* If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child’s birth/adoption/placement.

**Cost of COBRA Coverage**

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

**COBRA Continuation Coverage Payments**

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month’s premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier’s check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

**How Benefit Extensions Impact COBRA**

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
on the date of termination if you decide to terminate your employment during the leave.

**When COBRA Coverage Ends**

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.
Definitions

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent
The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, contact the Plan Administrator.

Employee
A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form
The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant’s home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant’s own serious health condition; or
- any qualifying exigency arising from an employee’s spouse, son, daughter, or parent being a member of the military on “covered active duty”. Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state’s family medical leave provisions, if applicable, contact your Employer.

GINA
HIPAA

HITECH
The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer
Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee
Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare
The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA
The Newborns’ and Mother’s Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant
An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA
The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
Any court order that: 1) provides for child support with respect to the employee’s child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA
The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA
The Women’s Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected
reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.
Adoption of the Plan

The Plan Document and Summary Plan Description for the West Shore Educational Service District Health and Welfare Benefit Plan, as stated herein, is hereby adopted as of 01/01/2019. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this __________ day of _________________________________, 2018.

BY: ________________________________

TITLE: ________________________________
## APPENDIX A

<table>
<thead>
<tr>
<th>BENEFIT PROGRAM</th>
<th>NAME OF INSURER/CLAIMS ADMINISTRATOR</th>
<th>POLICY OR CONTRACT NUMBER(S)</th>
<th>START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE</th>
<th>ELIGIBILITY</th>
<th>CLAIMS PROCEDURE &amp; BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP MEDICAL INSURANCE PPO</td>
<td>MESSA /BLUE CROSS BLUE SHIELD OF MICHIGAN</td>
<td>71452 71453-174, 175</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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<td>GROUP MEDICAL INSURANCE PPO</td>
<td>MESSA /BLUE CROSS BLUE SHIELD OF MICHIGAN</td>
<td>71452 71453-178, 179</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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<td>GROUP MEDICAL INSURANCE PPO</td>
<td>MESSA /BLUE CROSS BLUE SHIELD OF MICHIGAN</td>
<td>71452 71453-180, 181</td>
<td>January 1</td>
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<td>MESSA /BLUE CROSS BLUE SHIELD OF MICHIGAN</td>
<td>71452, 71453; 163 164</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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<tr>
<td>GROUP VISION BENEFITS</td>
<td>MESSA /VSP</td>
<td>All Employees</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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<td>BENEFIT PROGRAM</td>
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<tr>
<td>GROUP TERM LIFE INSURANCE BENEFITS</td>
<td>MESSA /CIGNA INSURER/CLAIMS ADMINISTRATOR</td>
<td>All Employees ($35,000)</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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<tr>
<td>ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE</td>
<td>MESSA /CIGNA INSURER/CLAIMS ADMINISTRATOR</td>
<td>All Employees ($35,000)</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
</tr>
<tr>
<td>LONG-TERM DISABILITY BENEFITS</td>
<td>MESSA /CIGNA INSURER/CLAIMS ADMINISTRATOR</td>
<td>All Employees</td>
<td>January 1</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
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