Plan Document

Whitmore Lake Public Schools

Minimum Essential Coverage Group Health Plan

Effective July 1, 2019

This Plan Document describes the features of the **Employer-sponsored, Minimum Essential Coverage Group Health Plan** (the "Plan"). The Plan provides employer-sponsored, minimum essential coverage. The Plan is made up of this plan document, subject to the limitations expressed in this Section, and all Benefit Documents.

This Plan Document sets forth the major features of the benefits program for eligible employees of Whitmore Lake Public Schools (the "District") as of 7/01/2019.

This Plan Document summarizes rights that participants have under the Plan.

Any oral or written statement or representation of any kind apart from this Plan Document does not alter this document or any Benefit Document maintained in conjunction with the Plan.

We intend to continue the Benefit Programs as described in this Plan Document indefinitely but reserve the right, at our discretion, to change or even terminate all or any part of the benefits offered at any time and in any manner to the extent permitted by law. As a result, this Plan Document is not a contract, nor is it a guarantee of your benefits.

If the District does modify or terminate any of the Benefit Programs offered, a subsequent Plan Document or Summaries of Material Modifications will be provided to advise you of any such modifications or termination.

Introduction

It is important to understand the health and welfare benefits available to you. That's why we prepared this Plan Document. The benefits available to you are designed to provide you with Minimum Essential Coverage as defined by 26 U.S. Code Section 5000A(f)(1)(B) and 26 U.S. Code Section 5000A(f)(2)(B).

WHAT'S INSIDE

This Plan Document contains important information on all required preventive services offers under the Plan. This Plan Document also serves as the official Summary Plan Description. This Plan Document is divided into the following sections to summarize the major features of the Benefit Programs offered to eligible employees:

- **Eligibility** gives you information about who is eligible to participate in the Plan, when coverage begins and ends, and important information about your rights upon termination of certain coverages.
- **Cost of Coverage** discusses who pays – you or us – for the various coverages, the tax status of payments.
- **Defined Terms** provides the meaning to be given to certain terms.
- **Benefit Program** describes important information regarding the Benefit Programs.
- **General Information** lays out the claims application, approval or denial, and appeals process, plan administration legal rules that govern the application and interpretation of plan provisions.

In Schedule A, at the end of this Plan Document, you will find contact information to obtain more information about your benefits, general administrative information regarding your rights and other important Plan information.

AN OVERVIEW OF YOUR HEALTH AND WELFARE BENEFITS

The Plan offers you preventive services at no cost to you when eligibility and premium-funding requirements are met.

Introduction

The chart below highlights the preventive services that are available to enrolled employees and their dependents under the Plan. These include:

1. Evidence-based items or services rated A or B in recommendations of the U.S. Preventive Services Task Force;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

4. With respect to women, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration; and

5. Any other preventive service that must be included within a group health plan under the Patient Protection and Affordable Care Act.

Introduction

Evidence-based items or services rated A or B in recommendations of the U.S. Preventive Services Task Force	Features
Abdominal aortic aneurysm screening: men	One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol misuse: screening and counseling	For adults age 18 years or older for alcohol misuse and to provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Aspirin to prevent cardiovascular disease: men	Men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin to prevent cardiovascular disease: women	Women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria screening: pregnant women	Urinary tract or other infection screening for pregnant women.
Blood pressure screening in adults	For adults aged 18 years or older.
BRCA risk assessment	Screening for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
and genetic counseling/testing	
Breast cancer preventive medications	For women who are at increased risk for breast cancer.
Breast cancer screening	For women age 40 and older, every 1 to 2 years.
Cervical cancer screening	For women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Chlamydia screening: women	For sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Cholesterol abnormalities screening: men 35 and older	For men age 35 years and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	Screening for men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women 45 and older	Screening for women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.

Introduction

Evidence-based items or services rated A or B in recommendations of the U.S. Preventive Services Task Force	Features
Cholesterol abnormalities screening: women younger than 45	Screening for women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	For adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Dental caries prevention: infants and children up to age 5 years	Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Depression screening: adolescents	Screening for adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Depression screening: adults	Screening for adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Falls prevention in older adults: vitamin D	Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic acid supplementation	For all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational diabetes mellitus screening	Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea prophylactic medication: newborns	Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	Screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hearing loss screening: newborns	Screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	Screening for sickle cell disease in newborns.
Hepatitis B screening: non-pregnant adolescents and adults	Screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	Screening for hepatitis C virus (HCV) infection in persons at high risk for infection. One-time screening for HCV infection to adults born between 1945 and 1965.

Introduction

Evidence-based items or services rated A or B in recommendations of the U.S. Preventive Services Task Force	Features
High blood pressure in adults: screening	Screening for high blood pressure in adults aged 18 years or older and obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: non-pregnant adolescents and adults	Screening for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
Lung cancer screening	Annual screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling: children	Screening for children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening: women	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Phenylketonuria screening: newborns	Screening for phenylketonuria in newborns.
Preeclampsia prevention: aspirin	Prescribe a low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24–28 weeks' gestation	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Skin cancer behavioral counseling	Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Tobacco use counseling and interventions: non-pregnant adults	U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	Provides behavioral interventions for cessation to pregnant women who use tobacco and advising pregnant women to stop smoking.

Introduction

Evidence-based items or services rated A or B in recommendations of the U.S. Preventive Services Task Force	Features
Tobacco use interventions: children and adolescents	Provides interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Syphilis screening: non-pregnant persons	Screening for persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	Screenings for all pregnant women for syphilis infection.
Obesity screening and counseling: adults	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling: children	Screening for children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening: women	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Phenylketonuria screening: newborns	Screening for phenylketonuria in newborns.
Preeclampsia prevention: aspirin	Prescribe a low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Sexually transmitted infections counseling	Intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
Skin cancer behavioral counseling	Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Tobacco use counseling and interventions: non-pregnant adults	U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	Provides behavioral interventions for cessation to pregnant women who use tobacco and advising pregnant women to stop smoking.
Tobacco use interventions: children and adolescents	Provides interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Syphilis screening: non-pregnant persons	Screening for persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	Screenings for all pregnant women for syphilis infection.
Visual acuity screening in children	Vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

As noted in the chart above, coverage for these benefits is automatically provided to you at the District's cost.

If you choose to decline coverage for these benefits, you do not have coverage through the District, and if you decline the health care coverage, you will not be eligible for COBRA benefits for the type of health care coverage you declined. In addition, if you decline coverage for benefits, you may not elect coverage until the next annual enrollment period (unless you experience a change in status or you qualify for an additional enrollment opportunity during the year). See "Changing Coverage During the Year" in the *Participation* chapter for details on the events that allow you to enroll in or change benefit coverages mid-year.

MORE INFORMATION

You should retain this Plan Document for future reference. If you have questions about your benefits, please contact the Whitmore Lake Public Schools Human Resource Office at:
Carol Henry, 8845 Main St., Whitmore Lake, MI 48189. 734-839-6308

CONTENTS: PARTICIPATION

Participation

This section gives you a roadmap on eligibility for the Plan, how to enroll for coverage in the Plan, when coverage begins and ends, special rights upon termination of coverage and how to file a claim for benefits.

ELIGIBILITY

Your Eligibility

You are eligible for the health and welfare benefits described in this Plan Document if you are a Full-time employee regularly scheduled to work for the District at least 30 hours per week.

For purposes of this Plan:

- A full-time employee is an employee who measures as working at least 30 hours on average during the district's applicable measurement period.
- A part-time employee is an employee who measures as working fewer than 30 hours on average during the district's applicable measurement period.

When Coverage Begins

Subject to certain exceptions and if you timely enroll for coverage, your coverage (and coverage for your dependent child(ren)) will generally begin as of the beginning of the district's applicable stability period. Payroll deductions for your share of the coverage costs will begin as soon as administratively feasible after your coverage begins and will apply back to your first date of coverage.

Excluded Individuals

Please note that you are *not* eligible to participate in this Plan if you are classified in any of the following categories, even if it is later determined that the classification is incorrect: a leased, seasonal, temporary, or on-call employee; an employee of an entity that is not a Participating Employer under the Plan; an intern; an independent contractor; or any other classification other than employee.

Your Eligible Dependents

Subject to certain limitations described below, you may enroll your dependent child(ren) for preventive service coverage. Your eligible dependents include:

- Your child who has not yet reached his or her the end of the year in which he or she attains age 26.
- For this purpose, Child includes:
  - ✓ Your natural children;
  - ✓ Your stepchildren or foster children living in your home;
  - ✓ Your legally adopted children (including children placed with you for adoption);
  - ✓ Child for whom you are a legal guardian; and
  - ✓ A child age 26 or older who, because of a mental or physical disability, lives with you and depends on you for financial support. The disability must have occurred before age 26. Proof of a mental or physical disability may be required to continue coverage past age 26. Contact Human Resources for details. In this case, the child's coverage will continue only while he or she is disabled.

Proof of Dependent Status

When you initially enroll a dependent, you will be required to provide documentation as proof of your dependent's eligibility status. The District reserves the right, at any time, to require you to provide appropriate documentation of your dependent's eligibility, such as a marriage certificate, birth certificate, adoption papers, guardianship papers or proof of disability.

Participation

Qualified Medical Child Support Order (QMCSO)

The Plan also provides health care coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for dependent coverage. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child.

A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the District to cover a child as your dependent under the Plan for health care coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or you would like to receive a copy of the written procedures for determining whether a QMCSO is valid, please contact Human Resources.

Dual Coverage

If your spouse also works for the District and is eligible for health care coverage, then he or she can enroll as an employee under his or her own coverage, but not as a dependent under your coverage. If you and your spouse are both employed by the District and eligible for health care coverage, only one of you may enroll your eligible dependent children.

Participation

ENROLLMENT

To receive coverage under the elective health and welfare benefits, you must timely enroll for those benefits. Your enrollment package will inform you of the specific methods of enrollment available and the specific time frames within which you can enroll.

There are three possible times at which you can enroll for coverage under your chosen benefits:

- Before your 31st day of eligible employment;
- During annual enrollment; and
- Within 31 days after you have a change in status or experience another event that allows you to make a mid-year election change.

Read on for more details of how to enroll and when your coverage becomes effective.

How to Enroll

Upon becoming initially eligible and before each annual enrollment, you will receive information from Human Resources regarding your enrollment options that will let you know how and when to enroll for coverage. If you need to make a mid-year election, please contact Human Resources for details on how to make any changes.

Coverage will become effective as described below depending on when you enroll. Payroll deductions for the cost of your elected coverages shall begin as soon as administratively feasible after coverage begins and will end effective as of the last day of your eligibility.

The elections you make - whether upon your initial eligibility, during annual enrollment or, if permitted, during the year - will stay in effect until you change them upon an event permitting a mid-year change in elections or during a subsequent annual enrollment period. This means your elected coverages will continue from Plan year to Plan year without further action on your part. It also means that if you do not have coverage under a program for one Plan year, you will not have coverage under that program for a subsequent Plan year, unless you enroll for coverage upon an event permitting mid-year enrollment or at annual enrollment.

Initial Eligibility

If you are a new District employee eligible to elect coverage or were previously an ineligible employee who becomes an eligible employee, you can enroll for coverage (including coverage for your eligible dependents) under your chosen benefits any time before your 31st day of eligible employment. Your enrollment materials will inform you of the current cost of coverages and what information is needed to complete enrollment. See "When Coverage Begins" above for information on the effective date of coverage.

If you do not enroll for coverage before the 31st day of eligible employment, your next opportunity to elect such coverages will be annual enrollment, unless a change in status or other event occurs that allows you to enroll for coverage before annual enrollment.

Annual Enrollment

Each year the District establishes an "Annual Enrollment Period" which is usually December 1-14. During the Annual Enrollment Period, you can make new benefit choices and elections for the upcoming Plan Year. The elections you make during annual enrollment generally take effect on the first day of the plan year**.**

Before the annual enrollment period begins, you will receive information that is designed to help you with your annual enrollment elections. This information describes the enrollment procedures, the coverage options available for the upcoming Plan year, your cost for each option, and any changes to the available coverages since the last annual enrollment period. Your enrollment materials contain important tips on how to enroll. Be sure to read the information carefully.

During annual enrollment, you have the opportunity to:

- Elect or decline medical coverage and add or drop dependents for the next plan year.

The following is an overview of the categories of events permitting you to make election changes to some or all of your health and welfare coverages:

- **Change In Status -** You experience a "change in status" – as described in this section – that affects your or your dependents' eligibility for health and welfare coverage;

- **HIPAA Special Enrollment -** You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

- **State Children's Health Insurance Plans –** You can enroll or drop your dependent mid-year if your dependent loses eligibility under a State Child Health Plan or becomes eligible for state premium assistance under Medicaid or through a State Child Health Plan.

- **QMCSO -** The Plan Administrator receives a Qualified Medical Child Support Order (QMCSO) requiring you to enroll a dependent child for health care coverage;

- **Medicare or Medicaid Entitlement -** You or your dependent enroll in or lose coverage under Medicare or Medicaid; or

- **Significant Cost or Coverage Changes -** The cost of the health and welfare coverages significantly increases or decreases, or coverage is significantly curtailed or lost.

Each of these events are explained in more detail below. Please note that these events permit you to change your elections after the elections take effect during a Plan year.

In contrast, if you enroll for coverages during the annual enrollment period, but your spouse's annual enrollment period occurs after the District's (but in the same year), you may make election changes that correspond with your spouse's changes without regard to the rules on changing coverage mid-year described here.

For example, assume you make your election coverages during the District's annual enrollment period that takes place in November. A month later in December, your spouse's employer conducts its annual enrollment period. If you want to make election changes under the District plan that corresponds with your spouse's elections, you may do so before the Plan year starts. Once the Plan year starts and your elections take effect, you will be permitted to make changes only pursuant to the rules described in this section.

Consistency Rule

For change in status elections under a health care program, any election change you make must affect eligibility under that program. In addition, regardless of what event you experience, any election change you make to any of your coverages must be because of and consistent with the event.

The Plan Administrator, in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

Election Period for Changing Coverages and Effective Date of Coverage

If you experience an event permitting you to change any of your health and welfare coverages, you must notify Human Resources and make your election changes within 31 days after the event. If timely made, coverage changes made due to a mid-year event are generally effective on the date of the qualifying event. Three exceptions are:

- For enrollment of a child pursuant to a QMCSO, coverage will be effective immediately after the Plan Administrator determines the QMCSO is valid,

- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of the date on which you acquired the child, and

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until annual enrollment to make any election changes.

In addition, you may be required to provide proof of your change in status or other event, if appropriate. If proof is requested and you do not provide proof, you cannot change your coverage until the next annual enrollment, unless you once again meet one of the events for a mid-year change. The Plan Administrator reserves the right to require, at any time, appropriate documentation of your change in status or other event.

Participation

Event: Change in Status

You can change your health and welfare coverages during the year if you experience a change in status occurs that affects eligibility for coverage under the Plan or under another employer's group health plan (such as the plan of a dependent's employer). A change in status is any of the following:

- You get married, divorced, legally separated or you have your marriage annulled;
- Your spouse, or dependent dies;
- Your dependent becomes eligible for coverage or ineligible for coverage;
- You acquire an eligible dependent child;
- You, your spouse, or other dependent experiences a change in employment status. Changes in employment status include any of the following:
  - ✓ Start or end of employment (See "Special Circumstances: Reemployment" above for unique rules in the case of reemployment);
  - ✓ Begin an unpaid leave of absence or a paid leave of absence becomes unpaid (details regarding coverage during a leave of absence are provided below);
  - ✓ Change in work site and your previous coverage is no longer available;
  - ✓ Change in hours of employment which impacts your eligibility for coverage;
  - ✓ Any other change in employment that leads to a loss of or gain in eligibility for coverage; or
- Your home residence changes and your previous coverage option is no longer available.

In addition to the above Change Events, you may also change your elections under the Medical Program if:

- you have a change in employment status that results in a change in work schedule from one in which you were reasonably expected to average 30 hours of service per week to a schedule in which you will be reasonably expected to average fewer than 30 hours of service per week, without losing eligibility to participate in the plan; and you wish to enroll in another plan that provides minimum essential coverage that will become effective no later than the first day of the second month following the month in which your coverage under this Plan is revoked.
- you become eligible to enroll in a health plan offered through the Health Insurance Marketplace, either because of a special enrollment right or during the Marketplace's annual open enrollment period, and your new coverage under such a plan will become effective no later than the day after your coverage under this Plan ends.

In either instance, you will be required to certify your intent to enroll in other coverage.

Important Notes Regarding Changes in Status:

- ✓ A newborn child will be automatically covered under the medical programs described in this Plan Document for the first 31 days after birth. An adopted child will be similarly covered. To receive coverage thereafter, you must enroll the newborn or adopted child, as the case may be, within 31 days after the child's birth or adoption.

For changes in status resulting in either you or a dependent becoming ineligible, note that coverage automatically ends as of the date of the event resulting in your or your dependent's ineligibility. A timely-made mid-year election change will stop the premium deduction that relates to the cost of coverage.

- ✓ Also, please note that if a dependent child is no longer eligible for coverage, your child, will lose health care coverage under the Plan at the end of the calendar month in which the event occurs. The individual losing health care coverage will have the right to continue coverage under COBRA. To exercise these COBRA

rights, the individual (or you, on the individual's behalf) must notify Human Resources within 60 days of the loss of coverage. Please see "Health Care Continuation Rights (COBRA)" later in this chapter for more information on COBRA.

Coverage During Leaves of Absences

As noted above, the beginning of an unpaid leave of absence is a change in status permitting election changes. To assist you in determining whether your leave is paid or unpaid triggering your right to make an election change, the following chart identifies which leaves will be considered paid and unpaid.

Paid LOA*	Unpaid LOA
▪ FMLA plus paid-time off	▪ FMLA and no other income source
▪ Sick leave	▪ Non-FMLA medical leave without District salary continuation
▪ Bereavement	▪ Voluntary military leave
▪ Jury duty	
▪ Involuntary military leave with pay differential	

*If any of these paid LOAs become unpaid, election changes may be made. Please contact Human Resources for details.

In the event you qualify for an unpaid leave of absence under the District's leave of absence policy (like an FMLA leave or personal leave), the following describes how your coverages may be impacted during your leave of absence and what happens when you return from a leave of absence.

- Continue to Participate in All or Some of Your Coverages

  The coverages in effect when you begin your leave of absence will automatically continue during your leave of absence. So, you will not have to complete any election forms if you want to continue your coverages during your leave, but you must still make your required contributions by paying the contributions over the course of your leave.

  During your leave of absence, you will be required to pay for your coverages with after-tax dollars. You will need to send a check to the District (or applicable third-party administrator or insurance company) at the beginning of each month to pay for your coverages.

Rules Regarding Failure to Pay for Coverage During Leaves of Absence:

If you take a leave of absence and payment for coverage received during your leave of absence is not received after the 30-day grace period for the second billing period expires, coverage will terminate retroactively to the beginning of the period for which payment was not made. If coverage terminates and you incur services during that period, your services will not be covered.

For example, you take a three month unpaid leave of absence that begins on March 1. You pay for coverage provided during the month of March. But, you do not pay for coverage provided in April or May. In this circumstance, your coverage will terminate effective as of March 1. Note that if your health care coverage is terminated due to your failure to

pay the required contributions, you will not have any COBRA rights.

- Terminate All or Some of Your Coverages

  You may choose to terminate your participation in any of your coverages. To do so, you must make a timely election within 31 days of the beginning of your approved leave of absence by notifying Human Resources. If you do not terminate your coverage during this election period, you cannot change your benefit elections until the next annual enrollment period unless you experience another event permitting a mid-year election change. In such circumstance, coverage will continue and you will be required to continue paying for coverage through the course of your leave of absence, as described above.

- Return from Leave of Absence in Same Plan Year

  If you terminate all or some of your coverages when you begin your leave of absence and you return from your leave in the same Plan year as when your leave began, those coverages will be reinstated upon your return.

- Annual Enrollment During a Leave of Absence and Return from a Leave of Absence in Different Plan Year

  If the annual enrollment period occurs while you are on a leave of absence, you will be sent an annual enrollment package and may make election decisions for the upcoming Plan year. To ensure you receive your annual enrollment package, please give your contact information to Human Resources so that the District has the most updated information for you during your leave.

  If you continue coverages during your unpaid leave of absence, then any election changes you make during annual enrollment will take effect as if you were actively at work. If you do not make any election changes, your elections in effect will continue.

  If you do not continue coverages during your unpaid leave of absence and make elections during annual enrollment, those elections will not take effect until you return from your unpaid leave of absence.

  If you are on an unpaid leave of absence and do not make new elections during annual enrollment, you will be given 31 days to make new election choices when you return to work, whether or not you continued your coverages during your unpaid leave of absence.

  If you do not make any elections during either annual enrollment or the 31 day election period upon your return, the coverages in effect during your leave will be continued. If you terminated coverage during your leave of absence and do not make any elections during either of these election periods, you will not have any elective coverage upon your return. In this case, you may have only the District-provided coverages, depending on which coverages you terminated before your leave of absence.

- Other Mid-Year Events

  Keep in mind that if you also experience another event permitting a mid-year change in coverage during your leave, such as a change in status and/or a HIPAA special enrollment event (discussed below), you may change your coverages in accordance with the rules for that event.

Event: HIPAA Special Enrollment

Under HIPAA, you have the right to enroll yourself and your dependents for medical coverage, even if you were not previously enrolled, within 31 days (60 days for events described in item 3) after the following special enrollment events:

(1) You declined medical coverage because you or your dependent had other coverage and the other coverage ends because:

  - ✓ You or your dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);

  - ✓ You or your dependents exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay contributions or cause); or

- ✓ Employer contributions toward the other group health plan coverage terminate.

If you timely enroll, coverage will take effect on the first day of the month following timely enrollment.

(2) You acquire a dependent as a result of a marriage, birth, adoption or placement for adoption. In the case of birth, adoption or placement for adoption, if you timely enroll, coverage will take effect on the date you acquired the new dependent. In the case of marriage, if you timely enroll, coverage will take effect on **[date]**.

(3) If you or your dependent loses coverage under Medicaid or a state child health plan under title XXI of the Social Security Act, or you or your dependent gains eligibility for premium subsidy assistance under Medicaid or a state child health plan.

If you do not request the change within 31 days (60 days for events described in item 3) of your special enrollment event, you lose special enrollment rights for that event.

Event: Enrollment Pursuant to a QMCSO

You, a custodial parent or a state agency may enroll your dependent child in health care coverage pursuant to the terms of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, which is determined to be a Qualified Medical Child Support Order (QMCSO). Alternatively, coverage for a dependent child may be revoked if the QMCSO requires the spouse, former spouse or another individual to provide coverage for the child. Only the child who is eligible for coverage pursuant to a QMCSO may be enrolled in or dropped from coverage.

A dependent child can be enrolled for health care coverage pursuant to a QMCSO only if any required contributions are made. This means that any required contribution for your dependent child's coverage will be withheld from your paycheck unless a state agency pays the required contribution. Coverage will be effective immediately following the Plan Administrator's determination that the order is valid.

Event: Medicare or Medicaid Entitlement

If you, your spouse or other dependent becomes entitled to Medicare or Medicaid coverage, you can drop District coverage for yourself or dependent child[ren], as the case may be. In contrast, if you, your spouse or other dependent lose Medicare or Medicaid coverage, you may enroll for District coverage for yourself or dependent child[ren], as the case may be.

Event: Significant Cost or Coverage Changes

A number of events come under this category, and are described below.

- The cost of coverage for a benefit option significantly increases or significantly decreases during the Plan year.

  The Plan Administrator, in its discretion, makes a determination whether an increase or decrease is significant triggering a right to make mid-year election changes. Any insignificant increases or decreases, as determined by the Plan Administrator, in the cost of coverage will be made automatically.

  If cost for a coverage option in which you do not participate significantly decreases, you can make an election to participate in that coverage option. In contrast, if the cost for your elected coverage option significantly increases, you can select another coverage option providing similar coverage. If no option provides similar coverage, then you can drop coverage.

- An event occurs that significantly curtails coverage or causes you to lose coverage.

  A significant curtailment of coverage can include such things as a significant increase in the deductible, the copayment or coinsurance amounts, and results in an overall reduction in coverage. In addition, the Plan Administrator may, in its discretion, treat a substantial decrease in participating physicians from a medical network as a significant curtailment of coverage. However, if you choose to participate in a medical option and your doctor leaves the network, your coverage is not considered significantly curtailed for purposes of this event.

These events allow you to change your coverage option to another coverage option providing similar coverage. If no similar coverage is available, then you may revoke coverage.

- A coverage option is added or significantly improved during the Plan year and you are eligible for it.

  In this event, even if you did not enroll for coverage, you can elect coverage under the new or significantly improved option.

- You or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution.

  This event allows you or your dependent to enroll for coverage. Note that if you gain eligibility for group health coverage sponsored by a governmental or educational institution, you may not drop your District coverage.

- The change corresponds with a change made by you or your dependent under another employer plan in the following circumstances:

  ✓ If the annual enrollment period under the other employer plan occurs at a different time of year than the District's annual enrollment and the other employer plan has a period of coverage that is different than the calendar year period of coverage provided under the District programs.

  For example, you elected medical coverage during the District's annual enrollment held in November. Your spouse's employer conducts annual enrollment in the following February for a 12-month Plan year that begins March 1. In this case, you can drop your District medical coverage if your spouse wants to enroll you as dependent in her employer's health plan; or

  ✓ If the other employer plan allows you or your dependent to change elections due to the reasons described above (change in status, special enrollment, QMCSO, Medicare or Medicaid entitlement and significant cost or coverage changes).

Summary of Events

The following chart illustrates the types of election changes under the elective health and welfare programs that would be considered consistent with some of the events described above. The chart is not an exhaustive list, but is simply meant to give you an idea of the types of election changes that could be made. As noted above, the Plan Administrator, in its discretion, has the authority to determine whether an election change is permitted.

Event	Permitted Change(s)
Birth/Adoption	Enroll child
Divorce	▪ Drop any ineligible children from coverage (COBRA triggered) ▪ Enroll yourself and children for coverage if lose other coverage
Loss of Other Health Coverage (HIPAA Special Enrollment)	Enroll for medical coverage only
Death of a Child	Coverage for that person ends
Paid Leave of Absence	No change permitted
FMLA Leave	▪ Drop coverage ▪ Continue coverage if monthly contributions are paid

Participation

COST OF COVERAGE

Payment of Coverages

The cost of the benefit coverages under the Plan will vary from year to year due to changing health care costs and inflation. During each annual enrollment period, you will receive the current costs of coverage (unless the coverage is automatically provided at the District's expense). You may contact Human Resources for current contribution rates.

Pre-Tax vs. After-Tax

You pay for coverage with pre-tax dollars deducted from your paycheck each pay period. Using pre-tax dollars reduces your taxable income for federal, Social Security, and (in most cases) state income tax purposes, making more of your paycheck available for you and your family. This means that you pay for the benefits without a tax cost. For many, this tax advantage may be significant.

Please note: Using pre-tax dollars can affect the Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pre-tax dollars. If you earn less than the Social Security "taxable wage base" ($118,500 for 2016) after making contributions to the Plan, your pre-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may, in turn, cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the Plan before you retire. In contrast, the reduction may be more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office. As always, you should consult a financial advisor about the effects of your participation in the Plan.

Coverage under the Plan is subject to payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

Remember, however, that income tax laws change frequently, and these changes affect different individuals in different ways.

Therefore, the District cannot assure you that it will be to your advantage to participate in the Plan.

COORDINATION OF BENEFITS

Your health care coverages coordinate benefits with other group plans that may cover you and/or your dependents. This feature helps prevent duplication of benefit payments for the same services. It is your responsibility to notify the Plan Administrator if you are covered by other plans.

Coordinating Plans

The following types of plans normally coordinate benefits:

- Plans provided by an employer, union, trust or similar sponsor;
- Other group health care plans that cover you or your dependent child[ren], including student coverage provided through a school above the high school level;
- Government Benefit Programs provided or required by law, including Medicare and Medicaid; and

Your health care coverages will consider any benefits to which you may be entitled from other group plans (even if you do not request payment from them) when determining the benefit payments made under the District Plan.

How Coordination with Other Group Plans Works

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then the other plans pay benefits.

Participation

If your District health care coverage is your primary plan, the Plan pays benefits up to the limits described in this Plan Document. When the District coverage is the secondary plan, it figures its regular benefit as if it were primary, subtracts from that amount the primary plan's benefits and then pays the difference. Therefore, the benefits payable from the District Plan may be reduced so that the benefits paid by all plans do not exceed 100% of the allowable expenses under the District Plan. Further, if the District Plan is secondary, its payments are limited to a maximum of what it would have paid if it were the only plan providing coverage.

Determining the Order of Payment

If you have health care coverage under a group health plan or Medicare in addition to your District health care coverage, National Association of Insurance Commissioners (NAIC) rules indicate which plan pays first. These rules prioritize how benefit payments are coordinated to avoid duplication of benefits.

Following is a summary of the NAIC rules. The primary plan pays before a secondary plan. The first rule that applies to you will determine which plan is primary and which is secondary.

- **Rule 1:** *No Coordination of Benefits Provisions*. If one plan does not have a coordination of benefits provision, then it is the primary plan, while the plan with the coordination provision is the secondary plan.

- **Rule 2:** *Dependent/Non-dependent.* A plan covering a person as an employee is primary over a plan covering that person as a dependent.

  Exception: There is an exception for Medicare beneficiaries whose Medicare coverage is secondary by law. If you are a Medicare beneficiary, please call Human Resources for more information.

- **Rule 3:** *Child of Parents NOT Separated or Divorced.* In this case, the Birthday Rule applies. Under the Birthday Rule, benefits are paid first by the plan of the parent whose birthday is earlier in the year. If, by chance, both parents have the same birth date, then the plan of the parent who has been covered longer pays first.

  For example, if Mom was born on March 21 and Dad was born on May 10, then Mom's plan is considered primary, regardless of the actual year in which they were born.

- **Rule 4:** *Child of Separated or Divorced Parents.* If a court order specifies that one of the parents is responsible for the child's health care coverage, the plan of that parent is primary.

  If the court decree awards joint custody without allocating responsibility for the child's health care coverage, the Birthday Rule determines which parent's plan is primary. If the parents do not share custody and no court order allocates responsibility for the child's health coverage, the plan of the custodial parent pays first, the plan of the spouse of the custodial parent (if any) pays second, the plan of the non-custodial parent pays next, and the plan of the spouse of the non-custodial parent (if any) pays last.

- **Rule 5:** *Active or Inactive Employee.* A plan that covers the person as a former employee or leased employee (or dependent of a former employee or leased employee) is secondary to a plan that covers the person as an active employee or leased employee (or as a dependent of an active employee or leased employee). If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule won't apply.

- **Rule 6:** *Continuation Coverage.* COBRA coverage is secondary to the plan covering the person as an employee or retiree. Note: This rule applies only when both plans provide either non-dependent coverage or dependent coverage to the person. However, if one plan provides dependent coverage and the other non-dependent coverage, Rule 2 applies.

- **Rule 7:** *Longer or Shorter Length of Coverage.* If none of the above rules determines the order of payment, then the plan that has covered the person longer pays before the plan that has covered the person for the shorter period of time.

- **Rule 8:** *Other Rules Don't Apply.* If none of the above rules determines which plan is primary, then the expenses are shared equally between the plans.

Participation

You must notify Human Resources any time you obtain or lose other health care coverage. If you or a covered dependent has primary coverage under another medical or dental plan, you must file a claim for benefits under that coverage before your District claim will be processed.

Coordination of Benefits for Participants Eligible for Medicare

If you are eligible for Medicare, the coordination of your benefits works differently from the National Association of Insurance Commissioners (NAIC) rules. Congress has established rules to determine whether Medicare or another plan pays first. This Plan Document provides a summary of how the Plan coordinates with Medicare, but you should refer to your medical Benefits Booklet for more details on the benefits available to Medicare-eligible individuals under the Plan.

How the Plan coordinates with Medicare depends on your age and whether you are an active or inactive employee. If you are an active employee and you are Medicare-eligible, the Plan is primary and pays benefits as described in this Plan Document. If the Plan is secondary to Medicare, the Plan pays the difference between what Medicare pays and the benefits available under the Plan. If you file a medical claim with the Plan, be sure to submit the explanation of benefits (EOB) you receive from Medicare. The combination of what Medicare pays and what the Plan pays may not exceed what the Plan alone would have paid. Under current law, you and your dependents become eligible for Medicare at age 65. If you become disabled, you may become eligible for Medicare before age 65. Please notify the Claims Administrator once you start Medicare benefits.

If You are an Active Employee

If you are an active employee and you reach age 65, you have coverage either:

- Under both the Plan and Medicare (the Plan is primary and Medicare is secondary); or
- Under Medicare only because you were not already covered under the District's plan.

If You are an Inactive Employee

If you are an inactive employee (e.g., you are on a disability leave) and you are Medicare-eligible, Medicare is primary regardless of your age. You are responsible for notifying Human Resources if you or your spouse becomes Medicare-eligible.

Coordination of Benefits for Participants Eligible for TRICARE

TRICARE is government-sponsored health care coverage for military personnel on active duty. The coordination of your benefits under TRICARE works differently from the Medicare and National Association of Insurance Commissioners (NAIC) rules. If you or your dependents are receiving benefits under TRICARE, generally TRICARE will be the secondary payer with respect to any benefit offered under the Plan. For more information on how TRICARE coordinates with employer provided group health plan coverage, please consult your TRICARE Plan Document or contact the Plan Administrator.

HOW LONG COVERAGE CONTINUES

Generally, your benefit coverages continue while you are still working with the District as an eligible employee and you are contributing your appropriate share of the cost of coverage. However, under certain circumstances, you (and your eligible dependents) may be eligible to continue your benefit coverages during leaves of absence or after your termination from employment, as provided in this Plan Document. If you (or your eligible dependents) elect to continue coverage, the benefits provided will be the same as those available to all other enrollees. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or following an election to continue coverage, the benefits available during the applicable continuation period will be subject to such changes. You may not, however, initiate new coverage at the beginning of a continuation period if you did not previously have such coverage.

Leaves of Absences

Unpaid Military Leave

If you lose coverage because you enter into active military duty covered under the Uniformed Services

Employment and Reemployment Rights Act (USERRA), you and your covered dependent are eligible to continue your health care coverage as long as you pay the cost to continue your District health care coverage. Under USERRA, the cost for the first 30 days of continuation coverage for you and your covered dependents is the same cost paid by active employees. The cost of continuation coverage after the first 30 days will be 102% of the full cost of coverage.

Your continuation coverage period is 24 months. The coverage period under USERRA will run concurrently with the required COBRA continuation period because the events giving rise to the respective rights occur at the same time. See "Health Care Continuation Rights" later in this chapter for more information about your rights to continue your health care coverage under COBRA.

Generally, to be eligible to continue your health care coverage (and coverage for your eligible dependents) while on active military duty, you must provide notice to the District of your absence from employment at least 30 days prior to your departure for military service, and must provide written notice to the applicable Plan Administrator of your desire to continue health care coverage within 60 days of your departure for such service. For more information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, please contact Human Resources.

Other Leaves of Absences

Your health and welfare coverages will continue during an approved paid leave of absence, whether or not your leave is taken under the Family and Medical Leave Act of 1993 (FMLA) and the cost of coverage will continue to be deducted from your pay on either a pre-tax or after-tax basis (as it was before your leave). If you choose, you may stop your health and welfare coverages during an *unpaid* leave of absence. But, if you continue coverages during your unpaid leave, required contributions for your elected benefit options are made with after-tax dollars. See "Changing Coverage During the Year" above for more details.

When Coverages End

Your Coverages

Your coverages end upon the first of the following to occur:

- Your employment with the District ends (e.g., you retire, quit, or are terminated);
- You are no longer eligible to participate (e.g., you are no longer a full-time employee);
- You fail to timely pay your required contributions;
- You elect to terminate coverage;
- You go out on strike or are locked out;
- You employer ceases to participate in the benefit program; or
- The District terminates the benefit program.

Termination of all coverages will be effective on the day the triggering event occurs.

Your Dependent's Coverage

Your dependent's coverages ends upon the first of the following to occur:

- When your coverage ends; or
- Your dependent no longer meets the eligibility requirements.

If you intend to leave the District, be sure to check with Human Resources about your benefit status as soon as possible. In addition, you or your dependent may be able to elect COBRA coverage for continued health care coverage after coverage ends.

HEALTH CARE COVERAGE CONTINUATION RIGHTS (COBRA)

COBRA

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependent to continue your

medical coverage (on an after-tax basis) in certain situations when coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverages. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

You may have other, more affordable 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. When deciding whether to elect COBRA Continuation Coverage, you should investigate these other options.

When to Elect COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your covered dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost. COBRA coverage is intended to extend the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, your District-provided health care coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

As noted above, if you elect COBRA coverage, you will receive the same coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While the District will notify the COBRA Administrator of your qualifying event in the case of your termination from employment (or service, as applicable), reduction in hours or death, it is your (or your covered dependent's) responsibility to notify the COBRA Administrator of any other qualifying event (e.g., divorce, loss of student status). In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

To continue coverage, you or your affected covered dependents (each, a "qualified beneficiary") are required to pay the entire cost, plus an administrative fee, as allowed by law.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify the COBRA Administrator of any event to trigger COBRA obligations, please contact your Human Resources representative. Upon any required notification by you, Human Resources will contact the COBRA Administrator to send you any necessary paperwork. The district's COBRA Administrator is Carol Henry 734-839-6308.

Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 reinstated the Health Coverage Tax Credit for certain individuals who become eligible for Trade Adjustment Assistance ("TAA"). Eligible individuals can either take a tax credit or get advance payment of up to 72.5% of their premiums for qualified health insurance, including COBRA Continuation Coverage. If you are a TAA-eligible individual who did not initially elect COBRA coverage, you have a second chance to make an election for COBRA continuation coverage during the 60-day period that begins on the first day of the month in which you become TAA-eligible if the election is made within six months after the date of the TAA-related loss of coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282 (TTD/TTY). More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

Participation

Snapshot of COBRA Coverage

Here is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for health care coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
Termination of your employment (or service, as applicable) for any reason except gross misconduct†	You and your enrolled dependents	18 months
Reduction in hours of employment (including a military leave of absence)†**	You and your enrolled dependents	18 months
You become laid off†	You and your enrolled dependents	18 months
You do not return from an FMLA leave of absence†	You and your enrolled dependents	18 months
If any of the above qualifying events apply and you or your covered dependent are disabled	You and your enrolled dependents	18 months up to 29 months***
Your death	Your enrolled dependents	36 months
Divorce or legal separation (unless a QMCSO provides otherwise)	Your enrolled dependents	36 months
Your child no longer meets the definition of dependent under the Plan	Your covered dependent	36 months

*The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event. If eligible for COBRA under the Health Care FSAs, the maximum COBRA period is through the end of the calendar year in which the qualifying event occurs.
**Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you will receive continued coverage at the same cost paid by active employees for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.
***See "COBRA Coverage for Disabilities" below for details.
†If you become enrolled in Medicare before your qualifying event, the maximum COBRA period for your enrolled dependents will be the greater of 18 months from the date of the qualifying event or 36 months from the date you become enrolled in Medicare

Important Notes:

- If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for health care coverage may be extended up to 36 months from the date you lost coverage on account of the first qualifying event.
- Please keep Human Resources informed of any change in your or your covered dependents' address so that you and your covered dependents can receive the necessary information concerning your rights to COBRA continuation coverage.

COBRA Coverage for Disabilities

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the

11 additional months of continuation coverage. (Any covered dependents can also continue their COBRA coverage during this extension period.)

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and
- Notify Human Resources within 60 days after the later of:
  - ✓ the date of the SSA's determination of disability; or
  - ✓ the date of the qualifying event.

If, during the 11-month disability extension, the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify Human Resources within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29 month period.

Reporting a Qualifying Event

You or your affected covered dependent must notify Human Resources either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following events:

- You divorce or become legally separated;
- Your child no longer meets the definition of a dependent (e.g. due to age limit); or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered dependent contact Human Resources, be sure to inform Human Resources of the specific event, the date of the event, and who is affected.

The COBRA Administrator sends you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

The local Human Resources representative informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage;
- You are laid off;
- You do not return from an FMLA leave of absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

Deciding Whether to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability).

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and

return it to the COBRA Administrator. In that case, your health care coverage ends on the day on which the qualifying event occurred.

When Continuation Coverage Ends

Continuation coverage ends when any of the following events occurs:

- You (or a covered dependent) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered dependent) do not pay a monthly contribution within 30 days of its due date;
- Upon your or your covered dependent's written request to cancel coverage;
- You (or a covered dependent) become entitled to Medicare;
- You (or a covered dependent) become covered under another group medical or dental plan that does not contain a pre-existing condition rule; or
- The District ceases to provide any group health plan coverage.

Please inform Human Resources of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

CLAIMS PROCEDURES

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you appeal a denied claim.

The sections of this Plan Document detailing specific benefits available under the Plan inform you whether or not you need to file a claim for benefits and, if you do, the information you need to complete a claim for benefits. When filing a claim, please check with the applicable Claims Administrator to be sure that its address has not changed.

This section informs you of the time frames for responding to initial claims as well as the appeals process. The time frames for responding to claims depend on the type of claim.

- The time frames for responding to initial claims for preventive coverage under the Plan are described in this chapter in the section entitled "Health Benefit Claims Process."

Under the Plan, all claims must be submitted within one year after the date the claim accrues (generally, when the services are or should have been provided). Please note that if a shorter time period is provided in the individual program sections, the shorter period will apply.

In no event can you (or any other person) challenge a decision in court until the applicable claims procedures have been complied with and exhausted. If, after you have exhausted the claims procedures, you wish to challenge the decision of the Plan Administrator or Claims Administrator, as applicable, you will have 12 months from the date you submit your last appeal to bring suit in a court of law.

What is a Claim?

There are two types of claims.

- ***Claim Regarding Eligibility or Enrollment.*** This is a claim involving eligibility for coverage under a benefit program or enrollment in a benefit program. Note that a claim regarding your eligibility may overlap with a claim for benefits (described below). That is, you may be denied a benefit because you are shown as not eligible to participate in the program that denied your benefit.

  The Plan Administrator, determines these types of claims. Please see General Information at the end of this Plan Document for contact information.

- ***Claim for Benefits.*** A claim for benefits is the more common type of claim and is a request that benefits be paid under the applicable program or a request that expenses be reimbursed. When you make a claim, you

generally receive an explanation of benefits (EOB) telling you that a claim has been made (even if you did not fill out the claim form), and how much, if any, of the claim is paid for under the health program. If an EOB denies or limits payment for the services or supplies provided to you, you can appeal that decision.

You may or may not need to file a claim to receive benefits. As mentioned earlier, the respective sections of this Plan Document will tell you whether a claim needs to be filed. Generally, if you receive in-network services, you do not need to file a claim form in order for the claim to be submitted to the Plan and to receive an EOB.

Health Benefit Claims Process

As noted above, the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan. A Claims Administrator has the authority to decide the level of benefits that are available to an individual. See the chart in the *General Information* chapter for contact information for the applicable Claims Administrators.

Initial Claim Decision

When a claim is received for a health benefit, the Plan Administrator must decide whether the individual is covered under the Plan or the Claims Administrator must decide whether (or at what level) the health benefit is covered under the Plan. When a health benefit is provided or denied, you will receive a notice explaining how the benefit level was calculated or why benefits have been denied (the EOB, generally). This notice must be given to you no later than 30 days after the claim is received (may be extended up to an additional 15 days.

This time period may be extended for up to 15 days as long as the Claims Administrator determines that such an extension is necessary due to matters beyond the Plan's control and notifies you before the original deadline. This notice will describe why the extension is necessary. If you do not properly submit all the necessary information for your request for benefits, the Claims Administrator must notify you and tell you what information is missing. You have 45 days to provide the information needed to process your request for benefits. While the Claims Administrator is waiting on your additional information, that time period does not count towards the time frame in which the Claims Administrator must decide your claim.

Appealing a Health Benefit Claim Denial

If you disagree with a coverage decision or denial, you (or your authorized representative) may request a full review by the Claims Administrator.

You must submit a request for review within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. If you want to appeal a decision on benefits, send your appeal to the Plan Administrator (for eligibility claims) or the applicable Claims Administrator (for benefit level claims) listed in the *General Information* chapter of this Plan Document.

Your appeal will be reviewed. Someone other than the person who made the first decision on your claim must make this review. The Claims Administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the Claims Administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of the Claims Administrator's findings and decision in writing.

Generally, this notice will be provided within 60 days.

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- Information to help you identify the claim;
- The specific reason or reasons for the decision, including any denial code and its corresponding meaning;
- The specific Plan provisions upon which the benefit decision is based;

- An explanation of the internal and external appeal procedures, including applicable time frames;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, standard, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- In the case of a denial on appeal, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; and
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review; and
- Contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

Before the Claims Administrator makes its decision, the Plan will notify you of any additional grounds for denying your Claim and provide you with an opportunity to present additional evidence in response. This evidence will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision on appeal.

The decision of the Claims Administrator following the decision on appeal is final, unless you elect to proceed to external review or file a suit in federal court.

External Review

Once you have exhausted the internal appeals procedures described above, you or your authorized representative has the right to request an external review from an Independent Reviewing Organization ("IRO"). The notice of denial on appeal that you receive will contain an explanation on how to submit information to the IRO. This external review procedure is voluntary and you are not required to use this level of appeal in order to have your claim determined by a court.

Generally, you will have the right to seek an external appeal if your claim was denied because of a medical judgment (such as health care setting, level of care, or effectiveness) or a rescission of coverage. You will have up to four months to file an external appeal.

If the claim involves experimental or investigational treatments, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

You will have an opportunity to provide additional materials to the IRO regarding the claim once the external review process is initiated. You will receive instructions directly from the IRO on how to supply additional information.

The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. After reviewing all of the information available to you and the Plan, the IRO will recommend whether the Plan should uphold or reverse the final determination of the claim.

The IRO's decision is binding on the Plan and you, except to the extent that other remedies are available under State or Federal law.

For more information about rights to an external review, you can contact the Employee Benefits Security Administration at 1 (866) 444-EBSA (3272).

Court Review and Failure to Follow These Procedures

All decisions of the Claims Administrator will be final and binding. If your claim is denied in whole or in part, you will have the right to file a civil action in court, but you will not be able to do so unless you have completed all of the levels of appeal (except any voluntary levels) required under the Plan. If you do not follow and complete these procedures, an appeal of your Claim in court will be subject to dismissal for your failure to exhaust your Claim and appeal rights under the Plan. This requirement that you exhaust the Plan's Claim

filing and appeal procedures applies not only to Claims for benefits, but also to Claims that the Plan Administrator, a Plan fiduciary, or the District has violated ERISA or the Code, and to decisions rescinding coverage. If you wish to file your Claim in court, you must do so within one year of the date on which you receive Notice of the Denial on Appeal. This one year limitation requirement applies to Claims for benefits, Claims alleging statutory violations of ERISA or the Code, or Claims that both seek benefits and allege statutory violations.

Failure of the Claims Administrator to Follow These Procedures

If the Claims Administrator fails to substantially comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat these procedures as having been completed, and immediately seek an external review or file your Claim in court. You must, however, file your Claim in court within one year of the date you knew, or should have known of the failure to comply with these procedures.

CONTENTS: GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Plan. If a Claims Administrator has the only review authority, the Claims Administrator's decision will be final and conclusive with respect to all questions.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

The District intends to offer the Plan indefinitely, but reserves the sole discretionary right to modify, amend or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or its designee. The District's decision to change or terminate the Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified. Subject to the terms of any collective bargaining agreement, no consent of any employee or any other person will be necessary for the District to modify, amend or terminate the Plan described in this Plan Document.

Because contributions for the health care programs stop on the date the Plan ends, the amount of Plan assets available to pay covered claims will not exceed the amount of Plan assets on the termination date.

Representations Contrary to the Plan

No employee, director or officer of the District has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or the District.

No Assignment

To the extent permitted by law, and except as specified under the terms of the Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO).

Fraud

The benefits under this Plan are for you and your eligible dependents only. If you or any one of your dependents makes a false representation to or commits any other fraud with respect to the Plan, the Administrator may permanently and retroactively terminate coverage for you and your dependents and seek reimbursement for any claims or expenses paid by the Plan as a result of the fraud. The Administrator may also pursue legal action against you.

General Information

Recovery of Payments Made by Mistake

You will be required to return to the District any benefits, or portion thereof, paid under the Plan by a mistake of fact or law.

No Contract of Employment or Service

Your participation in the Plan does not assure you of continued employment with the District or its affiliates or rights to benefits except as specified under the terms of the Plan. Nothing in the Plan or in this Plan Document confers any right of continued employment (or service, as applicable) to any employee or leased employee, as applicable.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan described in this book to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the Plan are provided on a self-insured basis by the District as shown in the following chart:

Self-Insured	
Benefits	▪ Medical Coverage (Non-HMO options)
Definition	As claims are made, covered benefits are paid from the District's general assets. However, the District has administrative services contracts with third-party administrators to decide on and process claims.

Please see the "Plan Information" chart at the end of this section for more details on which third-party administrators and insurance companies the District has contracted with to provide services and benefits.

Applicable Law

The Plan described in this Plan Document shall be governed and construed in accordance with the laws of the State of Michigan to the extent not preempted by the laws of the United States.

Governmental Benefits Exclusion

If services or benefits are reasonably available under any plan or program established by any government or under any plan or program in which any government participates (other than as an employer), benefits under the Plan are not payable for such services or benefits unless payment is legally required. In the case of any person who is not enrolled for all coverage for which he or she has become eligible under any such plan or program, services and benefits available shall nevertheless include all benefits to which he or she would be entitled if he or she were enrolled for such coverage. The term "any government" includes the federal, state, provincial, or local government or any political subdivision thereof of the United States or any country. This provision is subject to any provision or regulation of such plan or program that requires that benefits be utilized before benefits are available thereunder.

Interpretive Authority

If the Plan document does not clearly dictate whether an expense is eligible under the Plan and/or what percentage of the eligible charge is covered, the Claims Administrator will make a determination and pay benefits accordingly.

Except as provided above, if a question arises as to the interpretation of the terms of the Plan document, the Plan Administrator has discretionary

authority to interpret, construe, and apply the terms of the Plan document and to decide any such question, including but not limited to a question as to an employee's eligibility to participate in the Plan.

Genetic Information Nondiscrimination Act

The Plan shall comply with the provisions of the Genetic Information Nondiscrimination Act of 2008, as amended from time to time, with respect to any benefit option that provides health benefits. A Benefit Program that provides health benefits shall not require that you, or your eligible dependent, undergo genetic testing, nor shall the Plan use genetic information related to you or your eligible dependent, as a basis for determining eligibility to participate in the Plan or for the determination of any required employee contribution for any health benefit provided under the Plan.

Mental Health Parity and Addiction Equity Act

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as amended from time to time, to the extent that MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to provide coverage for mental health and/or substance abuse disorder benefits. This section will not create any rights in excess of the minimum required by law.

As the medical Benefit Program under this Plan allows for the designation of a primary care provider, you have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your covered dependents. For children, you may designate a pediatrician as the primary care provider.

A female participant does not need prior authorization from the Plan to obtain access to obstetrical and gynecological care from a health care professional in the Plan's network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals

Insurance Rebates

If the District or Plan receives an Insurance Rebate or other distribution from an Insurance Company in connection with medical loss ratio standards as set forth in Section 2718 of the Public Health Service Act, the portion of such rebate or distribution attributable to participant contributions shall be utilized, at the sole discretion of the Plan Administrator, for any permissible plan purpose. Such purposes shall include, but not be limited to, the payment of future participant premium payments, benefit enhancements, or any other use permitted by law.

Forfeitures

Failure to claim any amount or cash any check that becomes payable to you or is paid on your behalf under this Plan within two years after such amount first becomes payable, will result in such amount being forfeited. Such amounts shall cease to be a liability of the Plan, provided due and proper care has been exercised by the Plan Administrator in attempting to make such payment.

Statement of ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Human Resources Office all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).

- Obtain copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to Plan participants

each year. The Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

- Under a group health plan, continue health care coverage for yourself or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after you have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the Plan Administrator to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department or Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Notice of Privacy Rights

The Plan Administrator is committed to maintaining the privacy of protected health information for participants in the Plan. This is a reminder that in compliance with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) a Notice of Privacy Practices is available to employees. This notice of Privacy Practices explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy or for further information regarding the issues covered by this Notice of Privacy Practices, please contact the Plan Administrator.

General Information

Notice of Women's Health and Cancer Rights Act

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides group health benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema (swelling caused by the removal of lymph nodes). Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Plan Sponsor	**Whitmore Lake Public Schools** Carol Henry, 734-839-6308 Employer Identification Number: 386004080
Plan Administrator	**Whitmore Lake Public Schools** Carol Henry, 734-839-6308 Employer Identification Number: 386004080
Plan Fiduciary	**Whitmore Lake Public Schools** Carol Henry, 734-839-6308 Employer Identification Number: 386004080
Plan Name	**Whitmore Lake Public School** Minimum Essential Coverage Group Health Plan
Plan Number	**501**
Plan Year	**July 1, 2019 – June 30, 2020**
Plan Type	The Plan is an employee welfare benefit plan offering group health plan coverage.

PLAN INFORMATION

Benefit Program	Funding	Claims Administration
Medical	Self-insured by **Whitmore Lake Public School** Carol Henry	**SET, Inc.** **415 W. Kalamazoo St.** **Lansing, MI 48933** **1-800-292-5421**
COBRA Administrator	Carol Henry 8845 Main St., Whitmore Lake, MI 48189	