10-26-2018
0053-01
17-MED-03-0434
K37322

# Contract
# between

# Ashland Vocational Teachers Association

# and

# Ashland County - West Holmes Joint Vocational School District Board of Education

**August 1, 2017 - July 31, 2020**

# Table of Contents


| Article # | | Page # |
|---|---|---|
| **ARTICLE I** | **PROFESSIONAL NEGOTIATIONS** | 7 |
| | A. Recognition | 7 |
| | B. Principles | 7 |
| | C. Negotiation Subjects | 7 |
| | D. Negotiation Procedure | 8 |
| | E. Reaching Agreement | 10 |
| | F. Impasse Procedure | 10 |
| | G. Implementation and Amendment | 11 |
| | H. No Reprisals | 11 |
| **ARTICLE II** | **GRIEVANCE PROCEDURE** | 12 |
| | A. Definitions | 12 |
| | B. Time Limits | 12 |
| | C. Communications | 12 |
| | D. Rights of Grievant and the Association | 12 |
| | E. Informal Level | 13 |
| | F. Formal Procedure | 13 |
| | G. Miscellaneous | 14 |
| **ARTICLE III** | **EMPLOYMENT** | 16 |
| | A. Discrimination in Education Programs and Hiring Practices | 16 |
| | B. Teacher's Function and Responsibility | 16 |
| | C. Recruitment and Appointment of Teachers | 16 |
| | D. Notification of Employment | 17 |
| | E. Tenure and Sequence of Limited Contracts for Teachers | 17 |
| | F. Contracts for Educational Support Personnel | 18 |
| | G. Evaluation and Probation of Teachers | 18 |
| | H. Non-Renewal of Teachers | 40 |
| | I. Educational Support Personnel Evaluation | 40 |
| | J. Non-Renewal of Educational Support Personnel | 42 |
| | K. Just Cause | 42 |
| | L. Program Elimination | 43 |
| | M. Release From Contract | 43 |
| | N. Seniority | 43 |
| | O. Reduction in Force (RIF) of Teachers | 45 |
| | P. Reduction in Force (RIF) of Educational Support Personnel | 48 |
| | Q. Employment Practices | 49 |
| | R. Right to Fair Share Fee | 49 |

S. Notification of Intent to Retire....51
T. Resident Educator Program....51

**ARTICLE IV** **TEACHING CONDITIONS**....56

A. Assignment and Transfer of Teachers....56
B. Job Descriptions....58
C. Substitute Teachers....58
D. Non-School Employment During the School Year....58
E. Class Size....58
F. School Calendar....58
G. School Booth....59
H. Student Handbook....59
I. Work Day....59
J. Class Scheduling....60
K. Miscellaneous Conditions of Employment....60
L. Professional Work Center....60
M. Academic Freedom....61
N. Maintenance of Standards....61
O. Extended Service Days/Professional Development....61
P. Transportation of Students....63
Q. Local Professional Development Committee....63
R. Labor Management Committee (LMC)....66

**ARTICLE V** **EDUCATIONAL SUPPORT PERSONNEL CONDITIONS**....68

A. Overtime Payment....68
B. Paid Holidays for Educational Support Personnel....68
C. Vacation for Educational Support Personnel....69
D. Hiring, Vacancies and Transfers of Educational Support Personnel....70

**ARTICLE VI** **LEAVE PROVISION**....72

A. Sick Leave Policy....72
B. Sick Leave....72
C. Sick Leave Transfer Program....73
D. Personal Leave....74
E. Perfect Attendance Incentive....75
F. Absence on School Business....76
G. Leave of Absence....76
H. Maternity/Paternity Leave....77

**ARTICLE VII** **PROFESSIONAL GROWTH** ..... 79

A. Professional Growth ..... 79
B. Attendance at Professional Meetings ..... 79
C. In-Service ..... 79
D. CDL Bus Endorsements ..... 79
E. Tuition Reimbursement ..... 80

**ARTICLE VIII** **SALARY AND FRINGE BENEFITS** ..... 81

A. Teacher's Salary Schedule ..... 81
B. Teacher's Salary ..... 81
C. Payment of Teacher's Salary ..... 82
D. Index Attached ..... 82
E. Supplemental Salaries ..... 82
F. Educational Support Personnel Salary Schedule ..... 83
G. Payment of Educational Support Personnel Salary ..... 84
H. Insurance Program ..... 84
I. Mileage ..... 87
J. Overnight Assignments ..... 87
K. Severance Pay ..... 87
L. Payroll Deductions ..... 88
M. STRS/SERS Pick-Up ..... 88
N. Teacher Salary Schedule Placement Related to Training ..... 88
O. Experience Credit on Salary Schedule (Teachers) ..... 90
P. Salary Reclassification (Teachers) ..... 90
Q. Representation ..... 90
R. OX Agreement - Vocational Teachers ..... 90
S. Employment Incentive ..... 92
T. Employment of Retirees ..... 92

**ARTICLE IX** **ASSOCIATION RIGHTS** ..... 95

**ARTICLE X** **MANAGEMENT RIGHTS** ..... 97

**ARTICLE XI** **DURATION OF AGREEMENT** ..... 98

**APPENDICES**

**Appendix A** Grievance Report Form ..... 99

**Appendix B** Certified Non-Classroom Personnel Observation Form ..... 102

**Appendix C** Certified Non-Classroom Personnel Evaluation Form ..... 104

**Appendix D** Professional Performance Evaluation ..... 105

**Appendix E** Self-Assessment Summary Tool ..... 108

**Appendix F** OTES Professional Growth Plan ..... 109

**Appendix G** OTES Improvement Plan ..... 111

**Appendix H** OTES Walkthrough ..... 118

**Appendix I** OTES Pre-Conference Questions ..... 122

**Appendix J** OTES Formal ..... 126

**Appendix K** OTES Post Conference ..... 131

**Appendix L** OTES Summative ..... 136

**Appendix M** Student Growth Measures ..... 138

**Appendix N** Continuous Improvement Plan ..... 139

**Appendix O** Sick Leave Transfer Program Donation Form ..... 141

**Appendix P** Sick Leave Transfer Program Application Form ..... 142

**Appendix Q** Teacher Salary Index 2017-20 ..... 143

**Appendix R** Teacher Salary Schedule 2017-18 ..... 144

**Appendix S** Teacher Salary Schedule 2018-19 ..... 145

**Appendix T** Teacher Salary Schedule 2019-20 ..... 146

**Appendix U** Educational Support Personnel Evaluation Form ..... 147

**Appendix V** Secretarial Salary Schedule 2017-20 ..... 149

**Appendix W** ESEA Qualified Aide Salary Schedule 2017-20 ..... 150

**Appendix X** Teacher Aide Salary Schedule 2017-20 ..... 151

**Appendix Y** Custodial Salary Schedule 2017-20 ..... 152

**Appendix Z** Cafeteria Aide/Cleaning Assistant Aide Salary Schedule 2017-20 ..... 153

**Appendix AA** Health Benefit Summary Plan Description.....154

**Appendix BB** Dental Benefit Summary Plan Description.....252

**Appendix CC** List of Student Organization Activities .....324

**Appendix DD** Approval Guidelines .....325

**Appendix EE** Format of Minutes.....326

**Appendix FF** Attendance Incentive Request Form.....328

**Appendix GG** Contribution Analysis .....330

**Appendix HH** Wellness Incentive Options .....331

ARTICLE I

## I. PROFESSIONAL NEGOTIATIONS

### A. Recognition

The Ashland County-West Holmes J.V.S.D. Board of Education (the "Board or the District") recognizes the Ashland Vocational Teachers Association, an OEA/NEA - LOCAL (the "Association"), as the sole and exclusive bargaining representative for the purpose of and as defined in Chapter 4117 Ohio Revised Code for all certified instructional and support staff. Recognition is for all professional non-supervisory personnel, educational support staff both full or part-time, whether under contract, either verbal or written, on leave, or on a per diem or class rate basis employed or to be employed by the Board performing or to perform any work currently being performed by certified instructional or educational support staff ("members"). Members shall be, but not limited to, teachers, guidance counselors, librarians, media specialists, attendance/library secretary, secretary/fees, guidance secretary, principal's secretary, early childhood aide, culinary aide, cafeteria aide, cleaning assistant/aide, maintenance, technology coordinator, account clerk, in-school suspension, and custodian. The Association recognizes that the Superintendent, principals, treasurer, treasurer's secretary/cashier, assistant to maintenance supervisor, payroll clerk, all adult education personnel both certified and classified and other administrative personnel as defined in Chapter 4117 Ohio Revised Code are excluded from the bargaining unit. The employer recognizes that Association representation will include any newly created position unless employment into the position is governed by Section 3319.02 of the Ohio Revised Code.

### B. Principles

The members have the right to join or not join the Association, but membership shall not be a prerequisite for employment or continuation of employment of any employee.

"Good faith" negotiations require that the Association and the Board be willing to react to each other's proposals. If a proposal is unacceptable to one of the parties, that party is obligated to give its reasons. "Good faith" requires both parties to recognize negotiations as a shared process.

### C. Negotiation Subjects

Negotiable matters shall be all matters with respect to wages, hours, terms and conditions of employment and the continuation, modification or deletion of an existing provision of a collective bargaining agreement (hereinafter the "Agreement").

D. Negotiation Procedures

1. Representation

The Board, or designated representative(s), will meet with the Association for the purpose of discussion and reaching mutually satisfactory agreements. All negotiations shall be conducted exclusively between said teams. The parties may call upon professional and lay consultants to assist provided that such consultants shall attend only as observers. The expense of such consultants shall be borne by the party requesting them.

2. Initiation of Negotiations and Timeline for the Bargaining Process

a. The Association or the Board may begin the collective bargaining process by giving written notice to the Association President, or the Superintendent. The process shall commence no more than one hundred eighty (180) nor less than one hundred twenty (120) days prior to the expiration date of the existing Agreement and shall be at a mutually acceptable time within seven (7) days of the date the notice was served.

b. The parties shall continue in full force and effect all the terms and conditions of the existing Agreement, without resort to strike or lock-out, for a period of sixty (60) days after the date the parties exchange proposal lists or until the expiration date of the Agreement, whichever occurs later. Negotiations can be extended if mutually agreed upon by both parties.

c. If the parties are not able to reach a successor agreement by the expiration date of this agreement, the parties agree to submit all unresolved issues to mediation utilizing the assistance of the Federal Mediation and Conciliation Service ("FMCS"). Any costs for facilities incurred will be divided equally.

Mediation constitutes the parties' mutually agreed upon, final and exclusive dispute settlement procedure and shall operate in lieu of the settlement procedures set forth in O.R.C. 4117.14.

If there has been no settlement by the expiration date of the Agreement, the employees shall have the right to strike as outlined in O.R.C. 4117.14(D)(2).

The negotiations procedure set forth in this Article supersedes and takes precedent over any inconsistent time limits or procedures set

forth in O.R.C. 4117.14, which statutory time limits and procedures are hereby mutually waived.

d. Nothing in this section shall be construed to prohibit the parties, at any time, from voluntarily agreeing to submit any or all of the issues in dispute to any other alternative dispute settlement procedure. An agreement or statutory requirement to arbitrate or to settle a dispute pursuant to a final offer settlement procedure and the award issued in accordance with the agreement or statutory requirement is enforceable in the same manner as specified in Division (B) of Section 4117.09 of the Ohio Revised Code.

3. Meetings

At the first scheduled negotiations meeting, the parties' official representatives shall meet for the sole purpose of submitting all subject items to be considered for negotiation. Once the agenda is approved, no new items may be introduced for consideration without mutual consent. The meetings shall be called at times mutually agreed and shall be held at a time other than during regular school hours.

Designated representative(s) of the Board shall meet at mutually agreed upon places and times with representatives of the Association for the purpose of affecting a free exchange of facts, opinions, and proposals in an effort to reach mutual understanding and agreement. Negotiating teams will consist of no more than four (4) members on each team as well as their designated representatives with one (1) member of each team acting as spokesperson.

4. Good Faith Negotiations

Both parties agree to conduct negotiations in good faith and to deal openly and fairly with each other on all matters. "Good faith" requires that each team come to the table with the intention of reaching mutual agreement. This involves reacting to proposals and counter-proposals with good and sufficient reasons based upon the best information available.

5. Caucuses

During a negotiations session, either team may call caucuses not to exceed thirty (30) minutes each, unless mutually agreed to extend the time. Either team may declare a recess when it appears meaningful progress cannot be obtained. A recess shall be for no more than forty-eight (48) hours.

6. News Releases

While negotiations are in process statements to the media may be issued as needed by either party. A copy of any media release shall be furnished to the other party at the same time and by the same method. Progress reports may be made to the represented bodies by either team at the discretion of that team.

7. Information

Upon request by the Association and in compliance with Ohio Revised Code 149.43, the Board shall supply, within one (1) day when available from the auditor, all public financial information relative to the operation of the General Fund of the District and all public information pertinent to items to be negotiated by the Association.

E. Reaching Agreement

As tentative agreement is reached on each item, it shall be reduced to writing, initialed by the official spokesperson of each team.

When the tentative agreement is reached on all items, the proposed agreement shall be submitted first to the Association for ratification and then to the Board for final approval. Board action shall occur within five (5) days of the receipt of the notification of ratification by the Association.

When approved by both parties, the Agreement shall constitute the contract and shall be binding on both parties.

If agreement is not reached within sixty (60) calendar days, unless extended by mutual consent of either party shall have the right to declare an impasse. The unresolved issue(s) shall be submitted to the impasse procedure.

F. Impasse Procedure

The dispute (impasse) resolution procedures shall be in accordance with Ohio Revised Code 4117 and the provisions of this Agreement.

In the event the Board and the Association are unable to reach agreement ten (10) days prior to the expiration of the existing Agreement, then the Association shall have the right to proceed in accordance with Section 4117.14D (2) and Section 4117.18(C) of the Ohio Revised Code, such right being modified by future changes, if any, to the Ohio Revised Code.

G. Implementation and Amendment

This Agreement may be amended or the provision(s) altered only by the mutual consent of the parties. Such amendment and/or altering may be 1) at the request of either the Board or the Association or 2) by the Superintendent as representative of the Board and by the President of the Association as representative of the Association, or 3) as may be required by Ohio Revised Code 4117. In any case, the finalization of such amendment(s) or altering shall be in accordance with the provisions of Article I, Parts D and E.

H. No Reprisals

No reprisals of any kind shall be taken by either side for participating in any part of the negotiation process, including preparation and research of proposals and/or membership on the negotiating team.

Any questions or disagreements with regard to the inclusions or exclusions of the bargaining unit shall be submitted to the State Employment Relations Board (SERB) for determination. Such submissions to SERB would normally be preceded by an effort to clearly identify and resolve the problem in accordance with the provisions of Ohio Revised Code 4117.

Recognition shall continue until such time that a new member representative is selected in accordance with Ohio Revised Code 4117.

ARTICLE II

## II. GRIEVANCE PROCEDURE

### A. Definitions

1. A grievance shall be defined as a complaint involving an alleged violation, misinterpretation, or misapplication of a provision(s) of the Agreement.

2. A grievant shall mean a member, a group of members, or the Association alleging that a violation, misinterpretation, or misapplication of the contract has occurred.

3. A group class action grievance shall have as its basis similar circumstances with regard to each member of the group.

4. A party of interest is the grievant(s) and any other individual(s) who may be required to take action against or against whom action might be taken in order to resolve the claim.

5. A day is defined as a calendar day regardless of a holiday or calamity day for teachers and educational support staff.

### B. Time Limits

1. Grievances shall be processed rapidly. The number of days indicated at each step shall be maximums unless extended by mutual consent of the parties involved at each step.

2. If the grievant fails to meet time maximums at any step of the procedure, the grievance shall be considered waived. If the Board or its agents fail to meet time requirements, the relief sought shall be implemented.

### C. Communications

1. All requests, grievances, relief sought and grievance dispositions shall be sent to the receiving party on approved forms (see Appendix A) by certified letter or personal service at each step of the procedure. If service is by personal service, the individual performing such service shall indicate the time and date of service and affix his signature thereto.

### D. Rights of Grievant and the Association

1. The grievant has the right to Association representation at all meetings and hearings involving the grievance.

2. The Association has the exclusive right to file grievances and to be present for the adjustment of grievances.

3. Grievance forms shall be exhibited in the appendix of this Agreement and it shall be the exclusive right of the Association to issue forms to grievants.

4. The Association shall have the exclusive right to determine whether to proceed to arbitration.

5. The Association and the grievant(s) shall receive copies of all communications in the processing of grievances.

E. Informal Level

1. The grievant shall first discuss the grievance with the Principal or in the case of Educational Support Staff, the Immediate Supervisor. If the grievance cannot be resolved informally to the satisfaction of the grievant/Association, the grievant/Association shall have the right to initiate a formal grievance at Level One.

F. Formal Procedure

Level One

If the grievance cannot be resolved at the informal level, the grievant shall file the grievance and the relief sought in writing to the Superintendent. If the written grievance is not lodged within sixty-five (65) days following the act or knowledge of the act or omission upon which the grievance is based, the grievance is waived and shall no longer exist.

Within seven (7) days after the filing of the written grievance at Level One, the Superintendent shall meet with the grievant. Within ten (10) days after the meeting, the Superintendent shall give to the grievant his disposition and his rationale for such disposition in writing.

Level Two

If the grievant is not satisfied with the disposition of the grievance at Level One or if no disposition has been made within the time limit provided, the grievant may within an additional ten (10) days, file the grievance and relief sought in writing to the Treasurer. Within ten (10) days, the Board shall hold a hearing with the grievant. Within ten (10) days following the hearing, the Board shall give to the grievant its disposition and rationale for such disposition of the grievance in writing.

Level Three

If the grievant and the Association are not satisfied with the disposition of the grievance by the Board, and the Association Executive Committee has investigated the grievance and has determined that it has merit, the grievant and the Association may, within ten (10) days of receipt of such written response, give written or email notice to the President of the Board of its intent to submit the grievance to an arbitrator.

The arbitrator shall be selected from a list of seven (7) names supplied by the American Arbitration Association. Selection of the arbitrator shall be determined by the Voluntary Labor Arbitration Rules of the American Arbitration Association. Such rules shall also govern the arbitration hearing and proceedings.

The arbitrator shall not have the authority to add to, subtract from, modify, change or alter any of the provisions of this Agreement in arriving at a determination of any issue presented. The arbitrator shall expressly confine himself to the precise issue(s) submitted for arbitration and shall have no authority to determine any other issue(s) not so submitted or to submit observations or declarations of opinion which are not directly essential in reaching the determination. The decision of the arbitrator shall be final and binding on the Board, the grievant, and the Association.

The costs for the arbitrator and the hearing room shall be shared equally by the Board and the Association.

G. Miscellaneous

1. All communications, regarding grievances, shall be reduced to writing and hand-delivered or mailed by certified mail, return receipt requested. The Board shall provide the Association with copies of all communications.

2. Constructive receipt by the Board shall be construed to be the delivery date to the appropriate supervisor's office.

3. Constructive receipt by the grievant/Association shall be construed to be the delivery date to the Association President.

4. Meetings and hearings held under this procedure shall be conducted at a time and place which will afford a fair and reasonable opportunity for all persons entitled to be present to attend.

5. All parties at interest shall be permitted to attend a grievance meeting or arbitration hearing with no loss of pay or benefits.

6. No reprisals or recriminations shall be taken against any grievant, the Association, or a party of interest that would be related to the filing and/or processing of the grievance.

7. A grievance may be withdrawn by the Association at any time without prejudice.

8. The Association President shall receive notification of date, time, and place of hearings and the Association shall be entitled to representation at such hearings. Such representation shall be determined solely by the Association. The adjustment of a grievance(s) shall not, under any circumstances, be inconsistent with the terms of this Agreement.

9. If, in the judgment of the Association Executive Committee, a grievance affects a group or class of members, the Committee may submit such grievance in writing to the Superintendent directly and the processing of such grievance shall begin at Level One.

ARTICLE III

## III. EMPLOYMENT

### A. Discrimination in Education Programs and Hiring Practices

The Board and the Association agree that neither party shall discriminate against each other or against any employee and/or applicant on the basis of race, color, creed, sex, religion, marital status, age, political affiliation, or disability.

The Compliance Officer shall handle all grievances of this nature.

School personnel will take whatever steps necessary for self-study to identify any discriminatory policies or practices and take whatever remedial action is needed. Records shall be maintained of what procedures are followed.

### B. Teacher's Function and Responsibility

The services of the teacher exist to carry on the actual work of instructing pupils, which is the essential service of the Ashland County - West Holmes Career Center. The teaching function is best discharged when the concept of instructing pupils is broad enough to include not only the teaching of certain subject matter, but also the supervision of other worthwhile activities which further the attainment in pupils of the function of public education.

Such activities as counseling, supervising health and safety, sponsoring school activities and organizations, working on curriculum committees and other approved projects, and making such reports and records as may be useful, may be considered as examples. The duties and responsibilities of all teachers must be considered in the light of such a broad concept.

The classroom teacher shall be directly responsible to the Principal of the school. Professional problems shall be taken directly to him or the respective supervisor.

The classroom teacher shall have channels through which ideas can be heard on all policies, administrative and instructional. Through the Principal, opportunities to study, discuss, and make recommendations on all policies that affect the entire school system shall be provided.

### C. Recruitment and Appointment of Teachers

The Board recognizes that the strength of the educational program is based on a strong teaching staff. It is necessary to maintain a strong recruitment program and at the same time retain those capable teachers already employed. It shall be the duty of the Superintendent to see that persons nominated for employment shall meet

all qualifications established by law and by the Board for the type of position for which nomination is made.

D. Notification of Employment

Contract and salary notices will be given to the regular teaching staff following the May meeting of the Board of Education and shall be received no later than June 1st of each year. Contract and Salary notices for educational support staff shall be received no later than June 1st of each year.

E. Tenure and Sequence of Limited Contracts for Teachers

1. Continuing service status shall be granted in the District in accordance with State law. It is the sole responsibility of the bargaining unit member to notify the administration of their eligibility for a continuing contract.

   If a teacher should become eligible for a continuing contract during the term of a limited contract, the Board shall, at its next regularly scheduled May meeting, upgrade the individual contract to the continuing contract status.

2. Limited contracts shall be approved by the Board on the recommendation of the Superintendent as follows:

   a. A one-year limited probationary contract will be granted for the initial two (2) years of employment. If reemployed for a third year of employment, a one-year limited contract will be issued.

   b. Two-year limited contracts will be granted after three (3) years of continuous employment and the member is recommended for reemployment.

   c. Three-year limited contracts will be granted after five (5) years of continuous employment and the member is recommended for reemployment.

   d. Five-year limited contracts will be granted after eight (8) years of continuous employment and the member is recommended for reemployment.

3. Extended Limited Teaching Contracts

   In the event the Superintendent believes an extended limited teaching contract (not to exceed two [2] years) is warranted for a teacher who is otherwise eligible for a continuing contract, the teacher will receive written notice at least five (5) working days prior to any Board action along with

reasons directed towards professional improvement. The Board must act on an extended limited contract and the reasons directed toward professional improvement must be given to the teacher on or before June 1st. The parties agree the Board may bypass the procedures under Section 3319.11 (C) of the Ohio Revised Code and issue an extended limited teaching contract upon the Superintendent's recommendation without first entertaining a recommendation for a continuing contract. Upon subsequent reemployment of the teacher after the expiration of the extended limited contract, only a continuing contract may be entered into. If the Board does not give the teacher written notice of its affirmative action on or before June 1st, the teacher is deemed reemployed under a continuing contract at the same salary plus any increment provided by the salary schedule. The teacher is presumed to have accepted employment under such continuing contract unless such teacher notified the Board in writing to the contrary on or before June 15th, and a continuing contract shall be executed accordingly.

F. Contracts for Educational Support Personnel

1. Newly hired regular educational support bargaining unit members shall be given a contract for not more than one (1) year.

2. If such employees are rehired, the subsequent contract shall be for a period of two (2) years.

3. After the completion of the two-year contract if the contract of an educational support bargaining unit member is renewed, the educational support staff member shall be on a continuing contract. The salary provided in the last contract shall be matched or increased but may not be reduced unless such reduction is part of a uniform plan affecting all educational support staff of the District.

G. Evaluation and Probation of Teaching Staff

1. Definitions

a. Comparable Evaluations - Meeting the requirements as set forth in O.R.C., seniority may not be the basis for teacher retention or other employment decisions, except when deciding between teachers who have comparable evaluations, this refers to teachers within the categories of "Ineffective," "Developing," "Skilled," and "Accomplished.

b. Core Subject Area – means reading and English language arts, mathematics, science, foreign language, government, economics, fine arts, history and geography.

c. Credentialed Evaluator - For purposes of this process, each teacher subject to evaluation will be evaluated by a person who:

- Meets the eligibility requirements under R.C. 3319.111 (D); and
- Holds a credential established by the Ohio Department of Education for teacher evaluation; and
- Has completed State-Sponsored evaluation training and has passed an online credentialing assessment.
- For the 2014-2015 school year only, evaluation of an employee shall be conducted by the teacher's immediate supervisor. In the event a teacher performs work under the supervision of more than one supervisor, the Principal will designate the teacher's evaluator. The evaluator shall not be a bargaining unit member. The supervisor must be employed under a contract pursuant to Ohio Revised Code Section 3319.01 or 3319.02 and must hold at least one (1) certificate named under Division (E). (H), (I), (J), (K), or (L) of Ohio Revised Code Section 3319.22.

The Board shall authorize the Superintendent/designee to approve and maintain a list of credentialed evaluators as necessary. Members of AVTA shall be notified of their credentialed evaluator by the end of week one (1) of the start of school.

d. Evaluation Cycle - The period of time for the completion of the evaluation procedure. The evaluation cycle is completed when student growth measures resulting from assessments that were administered in the previous school year are combined with the teacher performance ratings resulting from performance assessments that are conducted for the current school year to assign an evaluation rating.

e. Evaluation Rating - The final summative evaluation level that is assigned to a teacher based on evaluations that are conducted pursuant to the terms of this agreement. The evaluation rating is assigned at the conclusion of the evaluation cycle when the teacher performance rating is combined with the results of student growth measures where fifty percent (50%) of the evaluation rating is based on student growth measures as provided for in this agreement and fifty percent (50%) of the evaluation rating is based on a teacher

performance rating as provided for in this agreement. Each completed evaluation will result in the assignment of one of the following evaluation ratings to the teacher: Accomplished, Skilled, Developing, or Ineffective.

f. OTES - stands for the Ohio Teacher Evaluation System as adopted by the Ohio State Board of Education in 2011, or as otherwise modified by the State Board of Education.

g. Promotion as used in this context is of limited utility given the fact that teachers covered by this Agreement are not currently employed in any discernible hierarchy. Nevertheless, when making decisions relative to such matters as determining department or grade level chairpersons, selections to curricular or strategic planning bodies, or teaching assignments, the Board will consider teacher performance as indicated by evaluations.

h. Remediation Plan - A written plan which shall be collaboratively put into place with the teacher and the assigned credentialed evaluator, in order to directly address any deficiencies cited in the evidence that is gathered during walkthroughs and formal observations.

i. Retention for purposes of this process refers to employment decisions on the question of whether or not to suspend a contract pursuant to a reduction in force, non-renew a limited or extended limited contract, or terminate employment for good and just cause. In the case of a reduction in force, seniority will not be considered when making decisions on contract suspensions, except in the instance of comparable evaluations. The decision to non-renew or terminate the contract of a poorly performing teacher may be informed by the teacher's evaluation(s) conducted under this process. However, decisions to non-renew or terminate a teaching contract are not limited by the existence of this process.

j. Shared Attribution - The practice of assigning student(s) growth results to a group of appropriately licensed educators who consistently meet to collaboratively plan and provide instruction and/or intervention for a student or defined group of students on a specific topic and/or grade level and which may or may not be reported in the teacher-student data linkage system.

k. Shared Attribution Measures – student growth measures that can be attributed to a group.

l. Student Growth – for the purpose of the District's evaluation process, student growth is defined as the change in student achievement for an individual student between two (2) or more points in time.

m. Student Growth Measure (SGM) - A unit of academic growth projected for a student over specified period of time, and which has been established according to a set of procedures defined either by the value-added data system provider employed by the State of Ohio or by the school district for approved vendor assessments or locally developed student learning objectives (SLOs).

n. Student Learning Objective (SLO) - A measurable academic growth target that a teacher sets at the beginning of the course/term for all students or for subgroups of students to be achieved by completion of an established interval based upon baseline data gathered at the beginning of the course.

o. Teacher – For purposes of the parties' evaluation process, "teacher" means licensed instructors who spend at least fifty percent (50%) of his/her time providing content-related student instruction and who is working under one of the following:

- A license issued under R.C. 3319.22, 3319.26, 3319.222 or 3319.226; or
- A permanent certificate issued under R.C. 3319.222 as it existed prior to September, 2003; or
- A permanent certificate issued under R.C. 3319.222 as it existed prior to September, 2006; or
- A permit issued under R.C. 3319.301.

Substitute teachers and teachers not meeting this definition are not subject to evaluation under this process. Certified non-teaching personnel will be evaluated utilizing the non-teaching evaluation procedures of the collective bargaining agreement in effect between the Board and AVTA (Appendix B, C and D)

p. Teacher of Record - A teacher who is responsible for assigning the grade to the student, and is required to have the proper credentials to teach the particular subject/grade level for which he/she has been designated "teacher(s) of record", and is responsible for a minimum of fifty percent (50%) of a student's scheduled instructional time within a given subject or course.

q. Teacher Performance - The assessment of a teacher's performance, resulting in a performance rating. As an evaluation factor, the teacher performance dimension is based on direct observations of a teacher's practice (including materials and other instructional artifacts) and walkthroughs that are performed by a credentialed evaluator. Teacher performance results are reported as a teacher performance rating that may be coded as "1" indicating lowest performance to "4" indicating highest performance.

r. Teacher-Student Data Linkage (TSDL) - The process of connecting the teacher(s) of record (based upon above definition) to a student and/or defined group of students' achievement scores for the purpose of attributing student growth to that teacher.

s. Value-Added – refers to the EVAAS Value-Added methodology provided by SAS, Inc., which provides a measure of student progress at the District and school level based on each student's scores on State issued standardized assessments.

t. Vendor Assessment – student assessments approved by the Ohio Department of Education that measure mastery of the course content for the appropriate grade level, which may include nationally normed standardized assessments, industry certification exams, or end-of-course examinations for grade level and subjects for which the Value-Added measure does not apply.

2. <u>The purposes of teacher evaluation are:</u>

a. To serve as a tool to advance the professional learning and practice of teachers individually and collectively in a school district.

b. To inform instruction.

c. To assist teachers and administrators in identifying and developing best educational practices in order to provide the greatest opportunity for student learning and achievement.

3. <u>Standards Based Teacher Evaluation</u>

a. Teacher evaluations will utilize multiple factors, with the intent of providing meaningful feedback to each teacher and assigning an effectiveness rating based in equal part upon teacher performance and student growth.

b. Each teacher evaluation will result in an effectiveness rating of:

- Accomplished;
- Skilled;
- Developing; or
- Ineffective

The specific standards and criteria for distinguishing between these ratings/levels of performance shall be the same as those developed by the State Board of Education, which are incorporated herein by reference.

The Superintendent shall annually cause to be filed a report to the Department of Education the number of teachers for whom an evaluation was conducted as well as the number of teachers assigned each rating as set forth above, aggregated by teacher preparation programs from which and the years in which the teachers graduated.

Fifty percent (50%) of each evaluation will be based upon teacher performance and fifty percent (50%) on multiple measures of student growth.

4. Assessment of Teacher Performance

Teacher performance will be evaluated during formal observations and periodic informal observations also known as "classroom walkthroughs." Such performance, which will comprise fifty-percent (50%) of a teacher's effectiveness rating, will be assessed through a holistic process by trained and credentialed evaluators based upon the following *Ohio Standards for the Teaching Profession:*

a. understanding student learning and development and respecting the diversity of the students they teach;

b. understanding the content area for which they have instructional responsibility;

c. understanding and using varied assessment to inform instruction, evaluate and ensure student learning;

d. planning and delivering effective instruction that advances individual student learning;

e. creating learning environments that promote high levels of learning and student achievement;

f. collaborating and communicating with students, parents, other educators, District administrators and the community to support student learning; and

g. assuming responsibility for professional growth, performance and involvement.

5. Formal Observation and Classroom Walkthrough Sequence

a. All instructors who meet the definition of "teacher" under R.C. 3319.111 and this process shall be evaluated based on at least two (2) formal observation cycles and periodic classroom walkthroughs each school year.

b. Teachers on a limited contract who are under consideration for renewal/nonrenewal shall receive at least three (3) formal observation cycles in addition to periodic classroom walkthroughs.

c. Pursuant to this process and Board resolution, the Board shall approve a list of projects recommended by the Superintendent/designee that demonstrate a teacher's continued growth and practice at the accomplished level for accomplished teachers who wish to complete a project in lieu of one (1) formal observation.

Evaluations will be completed on or before May 1st and each teacher will be provided a written report of the results of his/her evaluation on or before May 10th. Written notice of nonrenewal will be provided by June 1st.

In evaluating teacher performance in these areas, the Board shall utilize the measures set forth by the Ohio Department of Education's OTES "Teacher Performance Evaluation Rubric" for instructional planning, instruction and assessment, and professionalism, set forth herein in the Appendix BB.

Each teacher evaluated under this process shall annually complete a "Self-Assessment," utilizing the Self-Assessment Summary Tool (Appendix E). The teacher self-assessment tool shall be completed on or before September 15th of each year.

6. Formal Observation Procedure

a. A Formal Observation Cycle is comprised of:

- A minimum of two Walkthroughs that shall occur with a maximum of ten (10) with feedback provided within three (3) school days.

- One Pre-conference between the evaluator and employee preceding the formal observation in order for the employee to explain plans and objectives for the classroom situation to be observed. There will be at least one full workday notice given prior to the observation.

- One Observation of at least thirty (30) minutes.

- One Post-Conference within five (5) days following the observation unless mutually agreed upon by both the evaluator and the teacher.

- Teachers shall not receive a formal observation on a day before, during or after the following: the administration of standardized testing; a holiday or any break from scheduled school days (excluding weekends); or any approved leave of absence of three (3) or more days.

b. Observation Cycle One is to be completed prior to the start of Winter Recess

c. Observation Cycle Two is to be completed prior to May 1st but at least fifteen (15) scheduled school days after the completion of Cycle One

d. Observation Cycle Three (if required by contract type or deficiencies noted) shall be completed by May 1st but with at least ten (10) scheduled school days between Cycle Two and subsequent Cycles.

7. Walkthroughs

a. A walkthrough is a formative assessment process that focuses on the following components:

- evidence of planning; (learning goals are clear).

- lesson delivery; (the classroom environment is conducive to learning).
- differentiation; (all students are engaged in learning).
- resources; (teachers know the content they teach).
- classroom environment;(teachers differentiate instruction to support the learning needs of all students).
- student engagement; (teachers use resources effectively to enhance student learning).
- assessment; or (the teacher designs or uses assessments that match the learning objective).
- (instructional Practice).
- (instructional Strategies).
- (lesson Closure).
- or any other component of the standards and rubrics approved for teacher evaluation.

b. The walkthrough shall consist of at least five (5) consecutive minutes, but not more than fifteen (15) consecutive minutes in duration.

c. The teacher shall be provided a copy of the walkthrough form no later than three (3) work days following the walkthrough.

d. At the request of the teacher or evaluator, a formal debriefing may occur no later than three (3) work days after the walkthrough to discuss observation.

e. No more than ten (10) walkthroughs shall be conducted in each evaluation cycle.

f. Walkthroughs shall not disrupt and/or interrupt the learning environment in the classroom.

g. Data gathered from the walkthrough must be placed on the form designated as the Informal Observation Form. (Appendix H).

h. Walkthroughs may commence beginning with the sixth student day of attendance. Walkthroughs for the purposes of evaluation may occur through May 1st of each school year. This does not preclude administrative presence in any classroom and/or lab throughout the school year.

8. Assessment of Student Growth

In determining student growth measures, the Board adopts the Ohio Department of Education's Ohio Teacher Evaluation System (OTES), which calculates student growth by assessing achievement for an individual student occurring between two (2) points in time. It is important to note that a student who has forty-five (45) or more absences from a school day or from a specific teaching period for the school year will not be included in the determination of student academic growth unless mutually agreed by the teacher and evaluator.

In general, the Board will utilize the following categories to determine this aspect of a teacher's evaluation, depending upon the instructor involved:

A1. Teachers instructing in value-added subjects exclusively[1];

A2. Teachers instructing in value-added courses, but not exclusively[2];

OR

B. Teachers instructing in areas with Ohio Department of Education approved vendor assessments with teacher-level data available; or

C. Where value-added methodologies exist for A1 and A2 teachers, the Board will utilize them in the evaluation process, to the extent set forth in the "District Student Growth Measurement Index" (Appendix J).

[1] After July 1, 2014, the entire student academic growth factor of the evaluation (i.e. fifty percent (50%) shall be based on the value-added progress dimension.

[2] For these teachers, value added will be used for the student academic growth factor in proportion to the part of a teacher's schedule of courses or subjects for which the value-added progress dimension is applicable. Teachers with multiple subjects that have value-added data will be issued reports for a composite of reading and math; for other assessments (approved vendor and local measures), the assessment data measures should be representative of the teacher's schedule.

Teachers instructing in value-added courses, but not exclusively, will utilize teacher value-added and locally determined measures proportionate to the teacher's schedule.

When an approved Ohio Department of Education vendor assessment is utilized in the measurement of student growth, it will be included in the evaluation process for B teachers to the extent set forth in the "District Student Growth Measurement Index" (Appendix J).

When neither teacher-level value-added data nor Ohio Department of Education-approved assessments are available, the District shall use locally-determined Student Growth Measures for C teachers as set forth in the "District Student Growth Measurement Index" (Appendix J). Student Growth Measures may be comprised of SLOs, shared attribution[3], and/or non-Value-Added vendor data.

An SLO must be based upon the following criteria: Baseline and Trend Data, Student Population, Interval of Instruction, Standards and Content, Assessment(s), Growth Targets, and Rationale for Growth Targets. When new SLO's are developed or revised, the process will include consultation with teachers employed by the Board.

a. Student Learning Objective plans will be due by October 1st to be submitted to the SLO committee for approval. Other due dates will be determined by the SLO committee.

b. SLO's will be returned to the teacher by October 15th with approval or for revision.

c. A template and checklist for SLO's shall be provided.

d. Student growth data shall be provided to the evaluator/designee via the SLO scoring template on or before May 1st.

e. Documentation of student growth (the Pre- & Post-test, etc.) shall be maintained by the teacher for a period of one (1) year after the student leaves the Ashland County-West Holmes Career Center or as mandated by state law.

[3] If used, only one (1) "shared attribution" measure can be utilized per instructor.

Data from these approved measures of student growth will be scored on five (5) levels in accordance with the Ohio Department of Education/OTES guidance and converted to a score in one of five (5) levels of student growth:

- Most Effective
- Above Average
- Average
- Approaching Average
- Least Effective

9. Final Evaluation Procedures

Final evaluation is based upon ODE 600 point system and will be combined with the assessment of student growth measures to produce the summative evaluation rating, based upon the following "Evaluation Matrix"

| **Teacher Performance** | | | | | |
|---|---|---|---|---|---|
| | | 4 | 3 | 2 | 1 |
| Student Growth Measures | Most Effective &Above Average | Accomplished | Accomplished | Skilled | Developing |
| | Average & Approaching Average | Skilled | Skilled | Developing | Developing |
| | Least Effective | Developing | Developing | Ineffective | Ineffective |

The evaluator shall provide that each evaluation is submitted to the teacher for his/her acknowledgement by written receipt. The evaluation report should then be signed by the teacher upon receipt to verify notification to the teacher that the evaluation will be placed on file, but the teacher's signature should not be construed as evidence that the teacher agrees with the contents of the evaluation report.

The "Final Summative Rating of Teacher Effectiveness" (Appendix I) shall be provided to each teacher on or before May 10th.

10. Finalization of Evaluation

a. Written Report - Before the evaluation cycle is final, and not later than May 10th, a copy of the formal written evaluation report shall be given to the teacher and a conference shall be held between the teacher and the evaluator.

b. Completion of Evaluation Cycle

- The summative evaluation of a teacher shall be based upon student growth measures resulting from assessments that were administered in the previous school year and performance that is assessed through evidence gathered during the walkthroughs and formal observations that are conducted for the current school year.

- The evaluation shall acknowledge, through the evidence gathered, the performance strengths of the teacher evaluated as well as performance deficiencies, if any.

- The evaluator shall note evidence of all the data used to support the conclusions reached in the formal evaluation report.

- The evaluation report shall be signed by the evaluator; and the evaluation report shall be signed by the teacher to verify notification to the teacher that the evaluation will be placed on file. The teacher's signature shall not be construed as evidence that the teacher agrees with the contents of the evaluation report.

- The evaluation report shall be completed by May 10th, signed by both parties, and filed with the superintendent.

- Once every three years the board may evaluate each teacher assigned an evaluation rating of accomplished on the teacher's most recent evaluation conducted under this article who have received "Average" or "Above Average" growth. On non-evaluative years, one formal observation shall occur of at least thirty (30) minutes and the teacher shall receive a written report of the results of the evaluation by the tenth (10th) day of May of that school year.

- The Board shall only evaluate each teacher assigned an evaluation rating of "Skilled" once every two years. On non-evaluative years, one formal observation shall occur of at least thirty (30) minutes and the teacher shall receive a written report of the results of the evaluation by the tenth (10th) day of May of that school year.

- Final Summative Rating of Teacher Effectiveness (Effectiveness Rating) – The Superintendent shall annually

file a report to the Department of Education including only the following information: the number of teachers for whom an evaluation was conducted as well as the number of teachers assigned each rating (Accomplished, Skilled, Developing or Ineffective) aggregated by teacher preparation programs and the years in which the teachers graduated. All other information and documents obtained through the evaluation process shall be stored and maintained by district.

- A teacher shall be given by the district one (1) copy of all information and documents obtained through the evaluation process.

- The District shall submit the final summative rating of teacher effectiveness to the Ohio Department of Education by May 30th.

C. Response to Evaluation

The teacher shall have the right to make a written response to the evaluation and to have it attached to the evaluation report to be placed in the teacher's personnel file. A copy, signed by both parties, shall be provided to the teacher.

11. Due Process

At the teachers request, a teacher shall be entitled to association representation at any conference held during this procedure in which the teacher will be advised of an impending adverse personnel action.

12. Personnel Action -Requirements

a. High stakes employment decisions will not be materially informed by consideration of student/growth portion of the teachers evaluation unless or until there has been a minimum of three consecutive years of SGM data from the same grade level, subject matter, and/or age level i.e. 2015-2016.

b. The first year of collected data for the evaluation procedure shall be derived from value-added and other student growth measure scores from assessments taken in the school year following the effective date of this agreement. The first evaluation cycle shall be completed by first day of May of the second school year following the effective date of this agreement. An evaluation cycle shall not be completed

until all teachers have been provided with a written report of the results of the evaluation.

c. The evaluation procedure shall not be used for any decision concerning the assignment, re-assignment, or transfer of any teacher.

13. Professional Growth Plans (Appendix F) and Professional Improvement Plans (Appendix G)

a. Based upon the results of the annual teacher evaluation as converted to the "Evaluation Matrix" above, each teacher must develop either a professional growth plan or professional improvement plan as follows:

b. Teachers whose performance rating indicates above expected levels of student growth will develop a professional growth plan and may choose their credentialed evaluator from those available to the Board for that purpose

c. Teachers whose performance rating indicates expected levels of student growth will develop a professional growth plan collaboratively with his/her credentialed evaluator and will have input on his/her evaluator for the next evaluation cycle.

d. Teachers whose performance rating indicates below expected levels of student growth will develop a professional improvement plan with their credentialed evaluator. The administration will assign the evaluator for the subsequent evaluation cycle and approve the professional improvement plan.

A Growth or Professional Improvement Plan shall be completed prior to October 1st of each year beginning with the 2014-2015 school year.

e. All monitoring or observation of the work performance of a teacher shall be conducted openly and with full knowledge of the teacher.

14. Improvement/Remediation of Deficiencies Identified During Observations and Walkthroughs

a. Formal observations and walkthroughs resulting in the identification of performance deficiencies in relation to the approved standards and rubrics shall be addressed during the post-observation conference and/or the formal debriefing following a walkthrough.

All deficiencies identified by the evaluator shall be compiled and reported in writing, and a copy of the written report shall be provided to the teacher at the post-observation conference or formal debriefing.

b. The evaluator involved shall make written recommendations at the post-observation conference or formal debriefing and otherwise assist the teacher for the purpose of remediation of identified deficiencies.

c. The evaluator and teacher shall develop a plan for remediation of identified deficiencies at the post-observation conference or formal debriefing and such plan shall be reduced to writing and provided to the teacher within ten (10) working days following the post-observation conference or formal debriefing.

d. The remediation plan, as outlined in this section, shall detail the following:

- issues within the performance rubric documented as deficient;
- specific performance rubric expectations;
- sufficient and specific timelines to allow for the remediation of identified deficiencies.

e. If a remediation plan is developed prior to March 1st, the identified deficiencies shall be reevaluated as part of the performance assessment process for the remainder of the school year. For deficiencies that are successfully remediated during the remainder of the school year, those deficiencies shall be deemed remediated.

f. If a remediation plan is developed after March 1st, the teacher shall be permitted to continue remediation into the next school year.

g. Observed deficiencies regarding a teacher's failure to adhere to reasonable work rules and other documented deficiencies not noted during the formal observations or walkthroughs shall be put in writing and provided to the teacher within three (3) work days after an observed deficiency occurs. The evaluator shall provide to the teacher a written plan for remediation of said deficiencies with a clear and reasonable period of time for the teacher to evidence the required remediation.

h. In the event that a teacher and evaluator are unable to agree on the evaluator's expectation toward the improvement plan, the teacher may request a teacher mentor/coach or another mutually-agreed teacher of the district to facilitate further discussion between the teacher and the evaluator toward development of the improvement plan.

15. Student Growth Measures

a. When utilizing vendor assessments to construct SGMs, all related materials shall be purchased, and all affected staff shall be trained on utilization and other considerations prior to the students first day if available.

b. When utilizing SLOs to construct SGMs, the teacher shall submit the completed SLO template for approval of the SLO no later than October 1st.

- The SGM committee shall review and approve all submitted SLOs by October 15th.*

  *Consideration should be made for approval of SLOs.

- Any SLO that is rejected by the SGM committee shall be returned to the teacher/group with specific designation of deficiencies by October 15th with a timeline ten (10) days for the resubmittal of the corrected SLO.

c. Teachers shall administer the final assessment to determine student growth as defined in the approved SGMs.

d. Prior to submitting the SGM results to the designated evaluator, the teacher may request that the SGM Committee review the results for the sole purpose of verifying accuracy.

e. Teachers shall submit all SGM results to his/her evaluator within ten (10) workdays after the end of third (3rd) nine (9) weeks.

f. Evaluators shall conduct a final meeting with individual teachers to discuss SGM scores within twenty (20) workdays after the end of the third (3rd) nine (9) weeks.

16. Professional Development

The board shall meet the requirements of ORC 3319.112(A)(8)(9) to provide professional development. Annually, the board shall provide training on the teacher evaluation procedure for all credentialed evaluators and teachers prior to the implementation of the evaluation procedure, rubrics, tools, processes, and methodology, including the use of student growth data.

17. Funding for Orientation, Professional Development and Training

In accordance with the Ohio State Board of Education's statewide evaluation framework, the Board has adopted a specific plan for the allocation of financial resources to support the professional development of teachers covered by this policy. The plan will be reviewed annually.

18. SGM/SLO Committee

The SLO Committee shall be comprised of a minimum of three (3) teachers and one (1) administrator who have received training in the SLO process and shall annually meet no later than the end of October. The term of office and the selection of the teachers on the committee shall be determined by the Association President. The committee shall be responsible for reviewing, recommending for approval, and/or returning SLO's to the instructor for revision. Effort will be made to use release time during the regularly scheduled work day for the activities of the committee members.

a. Committee Operation

Members of the committee will receive training on the writing of student learning objectives (SLOs), value-added (including, but not limited to, ODE SGM trainings, teacher of record, shared attribution and teacher-student data linkage) prior to beginning their work, and any other training that may become necessary for the committee. (For example: when the district approves a new vendor assessment, all committee members and the bargaining unit will be trained on the new system and SGM application).

The committee shall establish by mutual agreement a meeting calendar, tasks for the committee to complete, and timelines for the completion of specific tasks.

One task of the committee shall be to determine those conditions that likely would impact SGMs, other than those attributed to teacher performance responsibility, such as a threshold number of

authorized teacher absences, the acceptance and mentoring of student teachers, changes in teacher assignments, implementation of the new standards and/or curriculum, etc.

All decisions of the committee shall be evidence-based and achieved by general consensus.

Members of the committee shall receive release time or compensation for work outside the contractual work day for committee work and training at the rate of twenty-five dollars ($25.00) per hour.

The committee shall be authorized to utilize consultant(s) (examples are, but not limited to, educational consultants, software consultants, SGM trainers, etc.) as deemed appropriate. The cost, if any, shall be borne by the board.

b. Committee Authority

The SGM committee shall recommend the policies and procedures for the student growth portion of the evaluation procedures to the association and the board.

The SGM committee shall not have the authority to negotiate wages, hours, or terms and conditions of employment.

The association and the board shall bargain as required in accordance with Ohio Revised Code 4117.

The SGM committee shall define the five (5) levels that count towards the final summative rating of teacher effectiveness:

| SLO Scoring Matrix Percentage of students that met or exceeded growth target | Descriptive rating | Numerical rating |
|---|---|---|
| 90-100 | Most Effective | 5 |
| 80-89 | Above Average | 4 |
| 70-79 | Average | 3 |
| 60-69 | Approaching Average | 2 |
| 59 or less | Least Effective | 1 |

19. Retention and Promotion Decisions/Removal of Poorly Performing Teachers

The evaluations produced will serve to inform the Board on employment decisions, i.e., retention, promotion of teachers, renewal of teaching contracts, and the removal/nonrenewal of poorly performing teachers.

Removal of poorly performing teachers will be in accordance with the nonrenewal and termination statutes of the Ohio revised code and the Collective Bargaining Agreement.

ORC 3319.17(c)

"In making any such reduction, any city, exempted village, local, or joint vocational school board shall proceed to suspend contracts in accordance with the recommendation of the superintendent of schools who shall, within each teaching field affected, give preference to teachers on continuing contracts. The board shall not give preference to any teacher based on seniority, except when making a decision between teachers who have comparable evaluations."

Nothing in this procedure will be deemed to prevent the Board from exercising its rights to non-renew, terminate, or suspend a teaching contract as provided by law and terms of the collective bargaining agreement. The evaluation system and procedures set forth herein shall no create an expectation of continued employment for teachers on a limited contract that are evaluated under this policy. The Board reserves the right to non-renew a teacher under this policy in accordance with R.C. 3319.11 notwithstanding the teacher's summative rating.

20. Joint Evaluation Procedure Review Committee

For the express purpose of recommending necessary changes to the Board for the appropriate revision of the Board's Standards-Based Teacher Evaluation Policy, an ongoing Joint Evaluation Review Committee shall be formed.

The Committee shall be comprised by an equal number of Association and Board representatives not to exceed a total of three (3) from each side. The term of office and the selection of the Association's members on the committee shall be determined by the Association President. The term of office and the selection of the Board's representative on the committee shall be determined by the Superintendent.

The Committee will review procedures and evaluation forms and recommend changes and/or revisions to the Administration as required by law.

a. Members of the committee shall receive training in all aspects of OTES, the state adopted evaluation framework, the standards for the teaching profession, teacher of record, shared attribution, and teacher-student data linkage prior to service on the committee.

b. The committee shall establish by mutual agreement a meeting calendar, tasks for the committee to complete, and timelines for the completion of specific tasks.

c. All decisions of the committee shall be achieved by general consensus.

d. Members of the committee shall receive release time for committee work and training as may be granted by the Superintendent.

e. The committee shall be authorized to utilize a consultant(s) (examples include, but are not limited to, educational consultants, software consultants, credentialing trainers, etc.) as it deems appropriate. The cost, if any, shall be borne by the board.

21. Committee Authority

a. The committee shall be responsible for jointly recommending changes and revisions to the policy, procedures, and processes, including the evaluation instrument, for teacher evaluation.

b. The committee shall not have the authority to negotiate wages, hours, or terms and conditions of employment.

Ashland County-West Holmes Career Center
Teacher Evaluation Chart

| Type of Current Contract | Evaluation Components | Reference Forms |
|---|---|---|
| One-Year Limited Contract | Three (3) Observation Cycles Annually | Teacher Self-Assessment<br>Professional Growth Plan<br>Teacher Evaluation Rubric |
| Multi-Year Limited Contract | Two (2) Observation Cycles Annually | Teacher Self-Assessment<br>Professional Growth Plan<br>Teacher Evaluation Rubric |
| Final year of Multi-Year or being considered for Non-Renewal | Three (3) Observation Cycles | Teacher Self-Assessment<br>Professional Growth Plan<br>Teacher Evaluation Rubric |
| Continuing Contract | Two (2) Observation Cycles | Teacher Self-Assessment<br>Professional Growth Plan<br>Teacher Evaluation Rubric |

* A teacher who received a summative rating of Accomplished on the teacher's most recent evaluation may complete an approved project in lieu of one (1) Observation Cycle.

An Observation Cycle shall consist of:

A minimum of two (2) walk-throughs

and

At least one (1) formal observation

Information observations may be required to gather missing data.

H. Non-Renewal of Teaching Staff

The Board and the Association agree that in the case of a non-renewal of a limited contract, the following requirements as specified in Ohio Revised Code 3319.11 that require the Board to provide the circumstances of a non-renewal, the requirement that the Board, upon request, hold a hearing on an intended non-renewal, and the right of a non-renewed teacher to appeal the Board's decision to non-renew to the appropriate common pleas court or the provision of the negotiated agreement shall be followed.

I. Educational Support Personnel Evaluation

1. Purpose

The purpose of the evaluation is to:

a. Assess the employee's work performance;

b. To help the employee achieve greater effectiveness in the performance of their work assignment;

c. To constitute the basis for personnel decisions including promotions, reassignments, continuation of employment or termination.

2. Evaluator

Evaluation of an educational support staff employee shall be conducted by the employee's appropriate supervisor. In the event an employee performs work under the supervision of more than one supervisor, the Superintendent will designate the employee's evaluator. The evaluator shall not be a bargaining unit member nor shall the supervisor be a bargaining unit member.

3. Frequency of Evaluation

The frequency of evaluation of the educational support staff is as follows:

a. An Employee shall be evaluated twice during the first full or partial year of employment (one-year contract).

b. An employee shall be evaluated once during the second year of employment and twice during the third year of employment (Two-year contract).

c. An employee shall be evaluated once every year during the fourth year of employment and thereafter (Continuing contract).

4. Evaluation Timelines

All evaluations for educational support employees shall be completed and forwarded to the Superintendent according to the following timelines:

a. One year limited contract

1) The first evaluation shall be forwarded to the Superintendent no later than the first Friday of February.

2) The second evaluation shall be forwarded to the Superintendent no later than the Friday prior to the April Regular Board of Education Meeting.

b. Two-year limited contracts

1) During the first year of a two (2) year contract, one evaluation shall be forwarded to the Superintendent no later than the first Friday of May.

2) During the second year of a two (2) year contract, the first evaluation shall be forwarded to the Superintendent no later than the first Friday of February. The second evaluation shall be forwarded to the Superintendent no later than the Friday prior to the April Regular Board of Education Meeting.

c. Continuing Contract

One evaluation shall be forwarded to the Superintendent no later than the first Friday of May.

5. Method of Evaluation

a. The formal evaluation of educational support staff shall be accomplished by a written self-evaluation prepared by the employee and a written evaluation of the employee prepared by the employee's supervisor.

b. The Educational Support Personnel Evaluation Form, Appendix U, shall be utilized for both the self-evaluation and the supervisor's evaluation.

c. Upon the completion of both written evaluations, the employee and supervisor shall meet to verbally discuss both written evaluations.

d. At the conclusion of this discussion, the supervisor shall finalize and sign the evaluation which will be presented to the employee for their signature.

e. The completed and signed evaluation form shall be forwarded to the Superintendent for review then included in the employee's permanent personnel file.

6. Miscellaneous

a. Nothing herein shall be construed to prohibit the normal supervisory functions of commending, questioning, suggesting, directing, reminding and correcting an employee in the performance of his/her duties.

b. An educational support member shall be entitled to Association representation at any conference held during this procedure in which the member will be advised of an impending adverse personnel action.

c. Within ten (10) days of receipt (a day when the employee is scheduled to work) the educational support member shall have the right to make a written response to the evaluation and to have it attached to the evaluation report to be placed in the member's personnel file. Failure to respond within the allotted time shall result in the member waiving his/her right to respond. A copy signed by both parties shall be retained by the member.

J. Non-Renewal of Educational Support Staff

The limited contracts of educational support staff may be non-renewed upon expiration of the contract by providing written notice to the affected employee before June 1st. A non-renewed educational support staff has the right to appeal the Board's decision to the appropriate Common Pleas court.

K. Just Cause

A member(s) shall not be disciplined, non-renewed, or otherwise deprived of any professional advantage without "just cause" and compliance with applicable provisions of this Agreement. Just cause, as it is used for nonrenewal, will not be applicable until the employee has completed a two (2) year contract in the Ashland County-West Holmes Joint Vocational School District.

L. Program Elimination

1. The Board agrees that provision should be made to give a teacher whose contract was terminated or suspended because of a program elimination an opportunity to be reemployed. As a result, the Board will agree to the following statement: "When a program is eliminated and a teacher is notified and dismissed because of this program elimination, then that teacher must be offered the opportunity to resume his or her position if that program or a similar program for which he or she is qualified and certified is later reinstated or begun. The reinstated teacher shall be placed on the existing salary schedule commensurate with training and teacher experience within legal limits of the law. A one-time refusal by the affected teacher will void future contact. The requirement to offer a teacher a contract under the above described circumstances ceases after two (2) years from date that respective teacher's contract is terminated or suspended."

2. In the event the reason for the elimination of a program is under enrollment, that teaching staff will be notified no later than March 1st for those programs which are under-enrolled at that time. Following this notice, the Board shall provide the Association President with the information/data on which their decision was based. Additionally, the teaching staff will be kept informed on enrollment changes and will be notified as early as possible of any program termination.

3. Any and all contract termination(s) or suspension(s) shall be in accordance with Ohio Revised Code 3319.16 and 3319.161, or 3319.17.

M. Release From Contract

A member may apply at any time for a release from contract. After July 10th, however, the Board may choose not to grant such a release based on inability to secure a satisfactory replacement.

N. Seniority

1. Seniority as used in this Agreement shall mean the length of continuous employment in a bargaining unit position as follows:

   a. Seniority shall begin to accrue from the first day worked in a bargaining unit position including responsibilities under a supplemental or extended time contract.

   b. Seniority shall accrue for all time a member is on active pay status or is receiving worker's compensation benefits.

c. Time spent on inactive pay status (unpaid leave or layoff) shall not contribute to the accrual of seniority but shall not constitute a break in seniority.

d. Full-time members shall accrue one (1) year of seniority for each year worked (120 or more days, 6 hours or more per day).

e. Part-time members shall accrue seniority prorated against the minimal full-time standard as defined above.

f. No member shall accrue more than one (1) year of seniority in any work year.

2. Equal Seniority

a. A tie in seniority shall occur when two (2) or more members have the same amount of seniority credit as determined by the seniority list.

b. Ties in seniority shall be broken by the following method to determine the most senior member:

1) The member with the first day worked; then

2) The member with the earliest date of employment (date of hire as determined by date of Board's resolution); then

3) By lottery, with the most senior member being the one whose name is drawn first, etc. This procedure shall be implemented in the presence of a designated Association representative.

3. Superseniority

For layoff purposes only, members employed under continuing contract shall have greater seniority than members employed under limited contract.

4. Loss of Seniority

Seniority shall be lost when a member retires or resigns; is employed in a full-time non-bargaining unit position; is discharged for cause; or otherwise leaves the employment of the Board.

5. Posting of Seniority List

A seniority list for teaching bargaining unit members and a seniority list for educational support staff bargaining unit members shall be posted twice annually, by October 1st and February 2nd of each work year. The Board shall prepare and post on the designated bulletin board in each building/work site a seniority list indicating, if applicable, by area of certification, license, or entry-level requirement, the first day worked, the date of Board resolution to hire, and the contract status (limited or continuing) of each member. Said list shall be provided to the Association President on or before the date of posting.

The names of members on the seniority list shall appear in seniority rank order within areas of certification, license, or entry-level requirement, with the name of the most senior member appearing at the top of the listing and the name of the least senior member appearing at the bottom of the listing.

The names of teachers who are certified, licensed, or otherwise minimally qualified in more than one (1) area shall be included on the listing for all areas of certification, license, or entry-level requirement.

The names of part-time members shall appear on the seniority list but shall be listed separately from the names of full-time members.

6. Correction of Inaccuracies

Each member shall have a period of fifteen (15) days after posting of the seniority list in which to advise the Board or its agents in writing of any inaccuracies which affect his/her seniority. The Board or its agents shall investigate all reported inaccuracies and make such adjustments as may be in order and post the updated list immediately. No protest shall be considered after fifteen (15) days of the posting of the seniority list and the list shall be considered as final until the next posting.

O. Reduction in Force (RIF) of Teachers

1. When, for any of the following reasons, the Board decides that it will be necessary to reduce the number of teachers it employs, it may make a reasonable reduction in accordance with the provisions of this section and Ohio Revised Code 3319.17:

(1) Return to duty of regular teachers after leaves of absence;

(2) Suspension of schools;

(3) Territorial changes affecting the District;

(4) Financial reasons; or

(5) Decreased enrollment of pupils in the district.

2. In making any such reduction, the board shall proceed to suspend contracts in accordance with the recommendation of the Superintendent who shall, within each teaching field affected, give preference to teachers on continuing contracts. The Board shall not give preference to any teacher based on seniority, except when making a decision between teachers who have comparable evaluations.

3. On a case-by-case basis, in lieu of suspending a contract in whole, the Board may suspend a contract in part, so that an individual is required to work a percentage of the time the employee otherwise is required to work under the contract and receives a commensurate percentage of the full compensation the employee otherwise would receive under the Contract.

4. Teachers whose continuing contracts are suspended by the Board pursuant to this section shall have the right of restoration to continuing service status if and when teaching positions become vacant or are created for which any of such teachers are or become qualified. No teacher whose continuing contract has been suspended shall lose that right of restoration to continuing service status by reason of having declined recall to a position that is less than full-time or, if the teacher was not employed full-time just prior to suspension of the teacher's continuing contract, to a position requiring a lesser percentage of full-time employment than the position the teacher last held while employed in the district. Seniority shall not be the basis for rehiring a teacher, except when making a decision between teachers who have comparable evaluations.

5. Suspended contract shall mean employed but on an inactive status without pay and/or fringes; however, the teacher would be entitled to benefits as described in Section 7 below.

6. The procedure for a reduction is as follows:

   a. The Association President shall be notified of the Board's intent to consider a RIF program prior to July 1st.

   b. A meeting(s) shall be held between the representatives of the Association and representatives of the Board to discuss the need for a RIF program.

c. A formalized RIF list shall be prepared indicating the specific number of positions to be abolished within each area of certification. The certification area(s) of teacher(s) who will be returning from approved leaves of absence will be separately indicated as a part of the formalized list. In addition, the number of teacher(s) who will be returning, within an area of certification, will be indicated.

d. This list shall be provided at least thirty (30) days prior to a RIF. The Association President shall receive two (2) copies of said list.

e. A teacher(s) whose contract(s) is/are suspended by the Board as a result of a RIF program shall be given written notification by registered mail immediately following the Board's regular meeting at which the action to RIF was taken. This notification shall indicate the date that the Board acted to suspend this teacher's contract and the effective date of the RIF.

f. The Board shall handle staff reductions through normal attrition (early retirement, resignations, etc.)

7. Vacancies

a. When a vacancy occurs for which the Board determines, a teacher notification will be made by registered mail and work email. It is the responsibility of the involved teacher(s) to advise the Board of the address where they can be reached.

b. A teacher who is offered a contract under the provisions of this policy must respond within ten (10) days of the receipt of said offer. If a teacher does not accept a contract or fails to respond in the time stated, the teacher will be removed from the recall list.

c. Upon reemployment, all rights related to salary, fringe benefits, and seniority shall be fully restored.

d. Teachers not employed as a result of the RIF program will be given first consideration as casual day-to-day or long-term substitute teachers as the need occurs if they submit their name for the substitute list.

e. RIFed teachers shall have the right to pay the total premium for hospital, surgical major medical, dental, vision, and prescription drug insurance for a period not to exceed eighteen (18) months. During the aforesaid eighteen (18) month time period, teachers

whose contracts have been suspended and who have not been recalled shall have the same contractual status as members who are on an approved unpaid leave of absence.

8. Recall List

All employees shall remain on the recall list for a period of twenty-four (24) months.

P. Reduction in Force of Educational Support Personnel

1. When by reason of decreased enrollment of pupils, return to duty of regular educational support staff after leave of absence, or by reason of suspension of schools or territorial changes affecting the district or for financial reasons, a reasonable reduction shall be made by suspending educational support member(s) of the bargaining unit contract(s), by the Board, in accordance with the provision of this section and Ohio Revised Code 3319.172.

2. In recommending the suspension of contract, the Superintendent shall give preference first to educational support employees under continuing contracts and then to educational support employees on the basis of seniority.

3. On a case-by-case basis, in lieu of suspending a contract in whole, the Board may suspend a contract in part, so that an individual is required to work a percentage of time the employee otherwise is required to work under the contract and receives a commensurate percentage of the full compensation of the employee otherwise would receive under the contract.

4. Any educational support employee whose continuing contract is suspended shall have the right to restoration to continuing service status by the Board in order of seniority in the District, if and when an Educational Support Personnel position for which the employee is qualified becomes vacant or is created.

5. No educational support employee whose continuing contract has been suspended shall lose the right of restoration to continuing service status by the Board in order of seniority of service status by reasons of having declined recall to a position requiring fewer regularly

scheduled hours of work than required by the position the employee last held while employed in the District.

Q. Employment Practices

1. The patterns, practices, and procedures as set forth in this contract shall be applied uniformly to all members except as may be otherwise required by statute or by this Agreement.

2. Regular teaching assignments will only be made in areas for which the member is or agrees to become properly certified.

3. A copy of Board policies and administrative rules and regulations will be available online

R. Right to Fair Share Fee

1. Payroll Deduction of Fair Share Fee

The Board of Education shall deduct from the pay of members of the bargaining unit who elect not to become or to remain members of the Ashland Vocational Teachers Association, a fair share fee for the Association's representation of such non-members during the term of this contract.

2. Notification

Notice of the name(s) of annual fair share fee payors (which shall not be more than 100% of the unfiled dues of the Association) shall be transmitted by the Association to the Treasurer on or about September 15th of each year during the term of this Agreement for the purpose of determining amounts to be payroll deducted, and the Board agrees to promptly transmit all amounts to the Ohio Education Association.

3. Schedule of Fair Share Fee Deductions

a. All Fair Share Fee Pays

Payroll deduction of annual fair share fees shall commence on the first pay date which occurs on or after January 15th annually. In the case of bargaining unit employees newly hired after the beginning of the school year, the payroll deduction shall commence on the first pay date on or after the latter of:

1) sixty (60) days employment in a bargaining unit position, or

2) January 15th.

b. Upon Termination of Membership During the Membership Year

The Treasurer shall, upon notification from the Association that a member has terminated membership, commence the deduction of the fair share fee with respect to the former member (amount of fee yet to be deducted shall be the annual fair share fee less the amount previously paid through payroll deduction). The deduction of said amount shall commence on the first date occurring on or after forty-five (45) days from the termination of membership.

4. Transmittal of Deductions

The Board further agrees to accompany each transmittal with a list of names of the bargaining unit members for whom all fair share fee deductions were made, the period covered, and the amounts deducted for each.

5. Indemnification

The Association on behalf of itself and the OEA and NEA shall indemnify and hold the Board harmless against any cost or liability that may arise out of, or by reason of, any action taken by the Board for the purpose of complying with the provisions of this Fair Share Fee provision. In the event that the Board is held to be responsible for the repayment of monies paid to the Association, the Association shall reimburse to the Board, or designated employee, the amount of monies actually received by the Association from the Board and/or designated employees involved.

6. Internal Rebate Procedure

The Association represents to the Board that an internal rebate procedure has been established in accordance with Section 4117.09(C) of the Ohio Revised Code, and that a procedure for challenging the amount of the representation fee has been established and will be given to each member of the bargaining unit who does not join the Association, and that such procedure and notice shall be in compliance with all applicable state and federal laws and the Constitutions of the United States and the State of Ohio.

7. Exemption for Religious Beliefs/Political Beliefs

Any person who objects to paying the Fair Share Fee because of religious and/or political beliefs may apply for either a rebate or an exemption as provided for in the Ohio Collective Bargaining Law.

S. Notification of Intent to Retire

Retiring members, excluding members who have previously retired through a state retirement system, who meet the STRS/SERS requirements for retirement shall receive a lump sum payment of $1,000 if they submit a letter of resignation for retirement purposes to the Superintendent and Treasurer in writing by December 1. The retirement resignation will be effective at the end of the current school year and shall specify the anticipated last date of employment. The retiring member must also complete the current contract in order to qualify for the payment. This may require possible adjustments for make-up of calamity days. The retirement resignation shall become irrevocable upon submission and shall be considered binding on the member and the Board of Education.

If a retiring member submits the letter of resignation as specified above for retirement purposes in their first year of retirement eligibility, in accordance with STRS/SERS guidelines, the member shall receive an additional ten (10) days of severance, paid in addition to Article VIII. K.

T. Resident Educator Program

1. Definitions

a. REP - stands for the Resident Educator Program as adopted by the Ohio State Board of Education and the Ohio revised Code, or as otherwise modified by the State Board of Education.

b. Resident Educator – For purposes of this policy, "Resident Educator" means licensed teacher/instructors needing to pas Resident Educator Program.

c. Lead Mentor – A bargaining unit member designated by the Superintendent with input from the Association, who is responsible for managing the District's Resident Educator Program. The final selection of the Lead Mentor rests with the Superintendent and/or his designee. Must be Resident Educator Trained

d. Mentor Teacher – A consulting teacher who will provide formative assistance to a Resident Educator. Must be Resident Educator Trained.

2. A mentoring program for all teachers needing to complete the Resident Educator Program shall be jointly provided in accordance with the Ohio Department of Education (ODE) Resident Educators Program Guidelines, the Ashland County-West Holmes Joint Vocational School District Board of Education and the Ashland Vocational Teachers Association (AVTA). An Resident Educator shall be defined as:

   a. An educator holding a 4-year Resident Educator License effective July 1, 2010 or later that is employed full time (120 days) in his/her area of licensure.

   b. Any teacher who needs to pass the Resident Educator State Assessment.

   c. Failure to complete Resident Educator yearly requirements may result in disciplinary actions including termination.

3. The Lead Mentor is a bargaining unit member designated by the Superintendent with input from the Association, who is responsible for managing the District's Resident Educator Program. The final selection of the Lead Mentor rests with the Superintendent and/or his designee. Must be Resident Educator Trained. The lead Mentors stipend will be paid $1,300 each year. The Lead Mentor stipend will be based upon the following requirements:

   a. A mentor teacher who will ensure that the Resident Educator Program requirements are met and who will facilitate the support provided to the Resident Educators and mentors.

   b. Conduct at least monthly meetings with mentors and resident educators

4. The Mentor Teacher is a consulting teacher who will provide formative assistance to a Resident Educator. Must be Resident Educator Trained. The Mentor teacher stipend of $700.00 will be based upon the completion of the following requirements:

   a. A mentor teacher who will ensure that the Resident Educator Program requirements are met and who will facilitate the support provided to the Resident Educators

b. Attendance at an orientation session with their assigned entry-year teacher

c. Completion of the Mentor Log/time sheet by both the mentor and Resident Educator teacher. Forms must be submitted to the lead mentor by the end of the first (1) semester and May 1st.

d. Completion of two (2) formal observations.

e. All mentors should participate in Tri-County entry-year training sessions. These hours count towards annual in-service requirements.

f. All mentors must attend, at a minimum, one monthly meeting directed by the lead mentor.

5. All bargaining unit members that have completed five (5) years of successful full-time classroom experience in the AC-WH JVS District shall be eligible to apply and fill a mentor-teacher position after completing Resident Educator Training.

6. The selection of bargaining unit members who will act as mentor teachers shall be considered based on those bargaining unit members who have submitted letters of intent. Potential mentors must meet all selection criteria:

   a. Completion of Five (5) or more years of successful teaching at the Ashland County-West Holmes Career Center

   b. Completion of the Resident Educator Training

   A letter of intent to serve, as a mentor, must be submitted to the mentorship committee. The Superintendent or Superintendent's designees shall make the final selection from the list of those who have properly submitted an intent letter.

   Should a position remain unfilled after all intentions have been assigned, the Superintendent or Superintendent's designees shall meet with the Association President, or the association's President's designee, to determine the method of filling the vacant position.

7. The Board shall provide release time of two (2) days per year for Mentor Teachers (and for the Lead Mentor) who are completing mentoring observations including pre- and post-observation conferences. Two (2) half

(½) days of release time per year will also be provided to Resident Educators to conference with their Mentor Teacher.

8. The Board shall provide an additional two (2) extended days per year for the Lead Mentor and Mentors to meet and plan the Resident Educator Program one (1) before start of school and one (1) at the end of school.

9. Six (6) weeks after the beginning of the school year, the Resident Educator Teacher may request, in writing, to the mentorship committee the reassignment of mentors. The mentorship committee will investigate the situation and will reassign, if appropriate. In the case of reassignment of an entry-year teacher from one mentor teacher to another for whatever reason, the stipend will be prorated between the mentor teachers mentoring the entry-year teacher. Mentors may also request reassignment to a different Resident Educator Teacher six (6) weeks after the beginning of the school year. The mentorship committee will investigate the situation and will reassign the Resident Educator Teacher, if appropriate.

10. Resident Educator are required to:

    a. Attend an orientation session on Resident Educator

    b. Work collaboratively with the assigned mentor

    c. Attend professional development meetings, designed to prepare participants for Resident Educator Program, at the Tri-County training sight.

    d. Be observed by the mentor a minimum of once per semester.

    e. Participate in the pre-observation and post-observation conferences for each observation

    f. Reflect on the descriptive feedback provided by the mentor from each observation

    g. Attend, at a minimum, one monthly meeting directed by the lead mentor

    h. Failure to complete Resident Educator yearly requirements may result in disciplinary actions including termination.

11. Joint Evaluation Procedure Review Committee

a. The Committee shall be comprised by an equal number of Association and Board representatives not to exceed a total of three (3) from each side.

b. The Committee will review procedures and evaluation forms and recommend changes and/or revisions to the Administration as required by law.

c. Members of the Committee shall be compensated with release time or (after the workday) at the contractual hourly rate (teaching conditions; Article IV, Section C 2 of the current AVTA contract).

ARTICLE IV

## IV. TEACHING CONDITIONS

### A. Assignment and Transfer of Teachers

#### 1. Assignment

All members are subject to annual assignment by the Superintendent. Recommendations from the Principal will be considered in making assignments. All members shall receive, in writing prior to the end of their last contractual work day each year, their tentative assignment for the ensuing school year relative to subjects, period, grade level, and/or extra duties. These assignments or extra duties could include but are not limited to tutoring, commons duty, and/or additional classes. Voluntarily working on High Schools that Work (HSTW) and/or Resident Educator License could exempt a staff member from assignment or extra duty as listed above. However, a member working in Year 1 and Year 3 of their Resident Educator License will exempt them from morning duties.

No change of assignment will be made after the end of the contract year except when an emergency situation arises and shall be in accordance with transfer procedures.

#### 2. Posting

All position openings for members, regardless of position or whether the opening implies a promotion, shall be posted on the District's website and emailed to all employees. Such notices will be indelibly dated at the time of posting.

Such notices shall clearly set forth the required certification for the position, a description of the duties to be performed, salary, and procedures for application.

If no applications are received within fourteen (14) calendar days of posting the notice via email to all employees the position may be filled outside the system.

A member hired to fill a position must possess the posted certification requirements for the position. Any member having proper certification may apply for the posted position and shall be granted an interview. When more than one (1) current bargaining unit member applies, requirements as set forth in O.R.C. (3311.79), seniority may not be the basis for teacher

retention or other employment decisions, except when deciding between teachers who have comparable evaluations.

3. Transfer Procedures

a. Voluntary Transfer - members may request a change of assignment.

1) Transfer requests may be initiated by members using the following guidelines:

a) A transfer request shall be emailed to the Superintendent by April 15th prior to the school year in which the transfer would occur.

b) Transfers will be considered if an opening exists or becomes available.

c) Members applying for a transfer will be interviewed for the open position. Positions shall be filled in accordance with the provisions of this article.

4. Involuntary Transfer - Every effort shall be made to avoid involuntary transfers by fully utilizing the voluntary transfer procedure. If the Superintendent directs an involuntary transfer in the department/division, subject or grade level, notification thereof shall be given to the involved teacher(s) by July 1st preceding the effective day of said involuntary transfer. No member shall be involuntarily transferred without just cause.

When involuntary transfers are necessary due to a staffing need, a teacher's area(s) of certification, his/her teaching experience, and length of continuous service in the district will be used as the criteria in determining if a member is to be transferred, (least service-first transferred).

Teachers being involuntarily transferred will be assigned only to a position for which they are fully and properly certified. In discussing an involuntary transfer, there will be a meeting (within five (5) days of a written request) of the teacher(s) involved and the Superintendent or his/her designee to explain the circumstances of the transfer. The involved teacher(s) may request representation of his/her choosing for the meeting. The involved teacher(s) shall be given the reasons for the transfer, in writing, prior to the aforementioned meeting.

B. Job Descriptions

Job descriptions shall be developed for the variety of positions included in the professional staff and educational support staff, and shall become a part of the rules and regulations of the District. The affected employee will be given a ten (10) day notice of any changes in their job description.

C. Substitute Teachers

1. Casual Day-to-Day Substitutes

Certificated substitute teachers may be employed when it is necessary for the regular teacher to be away from their duties.

2. Teacher Substitution

Teachers may be asked to substitute during the teacher's school day. A teacher who volunteers to substitute for another teacher will be paid twenty dollars ($20.00) per class period.

D. Non-School Employment During the School Year

Teachers or other staff members may not be gainfully employed by other than the Board of Education during the school year if such employment in any way interferes with regular duties.

E. Class Size

The administration will follow State standards on the issue of class size.

F. School Calendar

1. The Association Calendar Committee shall develop proposals for the school calendar and shall provide them to the Board by January 1st of each year.

2. The calendar that is adopted by the Board shall be in accordance with requirements as set forth in O.R.C. (3313.48) and the following:

a. The JVS calendar needs to reflect senior students completing required attendance prior to the earliest home school graduation.

b. The contract year for teacher shall be one hundred eighty-three (183) days of which no more than one hundred eighty (180) days shall include students in attendance.

c. Include at least the following holiday periods:

1) Labor Day.

2) Thanksgiving Day and the following Friday.

3) December recess to include at least ten (10) consecutive days which shall include for teachers December 24th and January 1st.

4) Spring recess - At least nine (9) calendar days aligning with the majority of our home school student population on break unless agreed by the association to make-up hours.

5) Good Friday.

6) Memorial Day.

G. School Booth

Only staff members volunteering their time will be involved in supervising the general school display booth at county and street fairs.

H. Student Handbook

Teaching staff will be given the opportunity to offer suggestions for revision and additions to the student handbook. When committees are formed to work on changes, teacher representation to the committee will be secured through the Association President.

I. Work Day

Except for those teachers who are assigned to teach at satellite locations and whose work day is separately established by the satellite school, teacher work day, including teachers who agree to teach a class beginning earlier than the start of the normal school day, shall not exceed seven (7) hours for any day that such teacher is scheduled to work in accordance with part F above. Said work day shall include no less than fifteen (15) consecutive minutes of non-student contact time within the first thirty (30) minutes of the day. Teachers who agree to teach a class beginning earlier than the normal school day will be exempt from the fifteen (15) minutes of non-student contact time at the start of the day

All teachers shall be entitled to thirty (30) minutes for a duty-free lunch period, and at least one (1) full class period of planning/preparation time which shall consist of consecutive minutes. The number of minutes in a period may fluctuate due to the

length of school day. The seven (7) hour teacher work day may be extended 1) by one (1) hour on one (1) occasion per month for nine (9) hours for the purpose of monthly in-service meetings; 2) for one (1) open house program per year; and 3) for one (1) parent/new student orientation which will occur the evening of the first contracted day. Teachers participating in the parent/new student orientation may be excused from two (2) hours of in-service except for those in-services that are mandated by State or Federal Law.

Teachers who agree to teach a class beginning earlier than the start of the normal school day shall be released prior to the end of the normal school day by the number of minutes that they teach prior to the start of the normal school day (flex-time). All flex-time assignments shall be based upon seniority by area of certification each school year.

J. Class Scheduling

Beginning no later than March of each year, each teacher shall receive, at least monthly, reports on the progress that is/has been made regarding registration of students for the ensuing school year. The administration will cooperate with and encourage each member who, at his/her option, is interested in participating and helping with the recruitment process. Teachers will make all reasonable effort in helping with student recruitment and retention.

K. Miscellaneous Conditions of Employment of Teachers

The following conditions of employment shall be adhered to:

1. Parent conferences shall be scheduled by teachers or shall be scheduled only with the agreement and consent at a time that is agreeable to both parent and member.

2. Teachers shall not be required to make the State mandated telephone call to the parent(s) of absent students.

L. Professional Work Center

The professional work center shall be maintained in the building and located in an accessible area. A functional copy machine, a computer, work table and an adequate supply of materials will be available for use.

In a private area of the building there shall be a telephone for members' use.

M. Academic Freedom

Each teacher has the right to perform his/her professional responsibilities in the classroom in a way he/she believes will best encourage a broad and complete understanding by students of educational subject matter. Such right shall be exercised within the bounds of professional responsibility and the Board adopted educational philosophy and curricula.

N. Maintenance of Standards

All conditions of employment, including but not limited to working hours, extra compensation for duties outside regular working hours, relief periods, leaves, and general personnel practices, shall be maintained at not less than the highest minimum standards in effect at the time this Agreement is signed, provided that such conditions shall be improved for the benefit of teachers as required by the express provisions of this Agreement. This Agreement shall not be interpreted or applied to deprive teachers of advantages heretofore enjoyed unless otherwise expressly stated herein.

O. Extended Service/Professional Development

1. An extended service day is intended to be utilized for professional development purposes or to extend service to non-scheduled school days. Employees utilizing extended service days will be paid at their per diem rate, based on the teacher's annual salary for regular teaching duties. Payment for extended days shall be made following the use of the extended service days and after submitting proper documentation verifying use of the day.

2. Extended Service Day Bank

   a. An Extended Service Days Bank will be made available for use by all teachers. The Extended Service Days Bank shall be no less than one hundred sixty (160) days.

   b. Each year, to be eligible for a day of extended time for home visits, a program instructor must make at least five (5) separate home visits with students who have been formally accepted to attend the Career Center. Instructors shall be eligible for one (1) Extended Service Day for the first five (5) students enrolled in their program for the following school year and then prorated 1/5 for each additional student. Up to a total of one- half of the available days in the Bank will be available for vocational program instructors for home visits during the summer. Home visits must be made during the summer prior to the start of the school year and documentation verifying each

student visit must be provided. If the Extended Service Days allocated for home visits are not used for home visits, they shall not be used for other purposes. The remainder of extended days shall be made available to all instructors who otherwise do not have extended time for use as recommended by the committee and approved by the Superintendent.

c. Each teacher who is interested in using an extended day during the following school year shall make written application to the Extended Service Days Committee by May 1st of each year. The application shall specify the number of days being requested, the purpose for the day(s) and, with the exception of home visits, the proposed date or dates the day(s) will be utilized.

3. Abuse or Falsification

Abuse or falsification of extended service/time days including professional development days may result in discipline including possible termination.

4. Committee

a. An Extended Service Days Committee composed of two (2) teachers, selected by AVTA, and one (1) administrator, selected by the Board, shall make recommendations to the Superintendent concerning the use of extended service days in the Extended Service Days Bank.

b. The Committee shall:

1) design and prepare guidelines for the use of these days,

2) develop criteria for the review of requests,

3) meet at mutually agreeable times during the workday,

4) establish the maximum number of days per employee,

5) recommend approval of days to the Superintendent one (1) week prior to the regular May board meeting.

c. The granting of requested days from the Extended Service Days Bank shall be approved by the Superintendent with consideration of the guidelines and criteria developed by the Committee.

d. In the event the requests for Bank days are less than the allocated number, the remaining days shall not be carried over and added to the next year's total.

e. Additional days over the one hundred sixty (160) bank may be distributed upon request with the approval by the Superintendent.

P. Transportation of Students

1. A member shall not be required to use a personal vehicle to transport students for any school purpose.

2. In the event that a member uses a personal vehicle to transport a student for approved school related activities, and with the permission of the Principal, the Board shall provide non-ownership liability insurance to the member for bodily injury and property damage coverage up to $1,000,000.00 combined single limit per the District's property/vehicle insurance policy.

3. Per the insurance policy, this insurance does not apply to injury caused as a result of intentional actions or liability assumed under any contract or agreement.

4. A copy of the District's automobile insurance policy shall be maintained in the Treasurer's Office.

Q. Local Professional Development Committee

1. Purpose

The LPDC shall be maintained with District-level scope to 1) oversee and review professional development plans for course work, continuing education units, and/or other equivalent activities, and 2) determine whether the course work that certificated/licensed personnel proposes to complete meets the requirements of the educator licensing rules.

2. Term of Office

The term of office for members serving on the committee shall be two (2) school years (July 1st through June 30th).

3. Committee Composition and Selection

a. The committee shall be comprised of five (5) members as follows:

Three (3) teachers employed by the District.

One (1) Administrator employed by the District.
The Superintendent or his/her designee.

Whenever an administrator's certificate/licensure renewal is being discussed or voted upon, the Local Professional Development Committee shall, at the request of one of its administrative members, cause a majority of the committee to consist of administrative members.

b. The three (3) teachers shall be selected by a majority vote of all teachers in the District and the administrator shall be selected by the Superintendent.

c. In the event of a vacancy, the committee member shall be filled by majority vote of all teachers in the District, unless the vacancy occurs during the last sixty (60) days of a term in which case it will be filled by a teacher selected by the Association President. Any teacher selected or appointed to fill such a vacancy prior to the end of the expiration of a term for which the predecessor was elected shall hold office as a member for the remainder of that term.

4. Chairperson

The Chairperson and other officers shall be elected by majority vote of the LPDC.

5. Decision Making

Decisions shall be made by a majority vote of the committee members present and voting.

6. Training

a. The LPDC will study all the issues involved in licensure. Relevant training is encouraged. In the event relevant training is offered by the State Department of Education, the committee members shall be given paid release time to attend such training if the training occurs during the regular school day.

b. In the event specific funds for LPDCs are made available from the State, the committee shall have the discretion as to how best to utilize those funds.

c. LPDC members shall be reimbursed for mileage, meals, lodging, parking and registration at District-approved rates to attend relevant training offered by the State Department of Education.

7. Meetings and Compensation

a. The initial meeting shall be called by the Superintendent or his/her designee by September 10th each year. Additional meetings may be scheduled as necessary and posted.

b. At the initial meeting, the LPDC shall review this Article and prepare rules for conducting its meetings.

c. All meetings shall be held before or after regular school hours.

d. Committee members shall receive a five hundred dollar ($500.00) stipend for serving on the Committee. Said stipend shall be paid at the last pay of June.

8. Appeals Process

a. Level One

1) Any teacher wishing to appeal the decision of the LPDC may petition the Appeals Committee in writing for review within seven (7) days of the LPDC's decision.

2) The Appeals Committee shall render its decision within fourteen (14) days of receipt of the appeal.

3) The Appeals Committee shall be comprised of the AVTA President, a teacher from the same discipline, and the Superintendent's designee.

b. Level Two

1) Any teacher wishing to appeal the decision of the Appeals Committee may petition the Board of Education Appeals Committee by filing a written appeal with the Treasurer for review within seven (7) days of the Appeals Committee decision. The Board of Education Committee shall consist of three (3) members of the Board of Education appointed by the Board.

2) Upon receipt of an appeal from the Appeals Committee the Board of Education Committee shall render its decision within fourteen (14) days of receipt of the appeal.

3) The Board of Education's decision shall be final.

9. The LPDC shall keep and retain records of its meetings, decisions, and recommendations.

10. The LPDC shall not have authority to revise, change, delete, or modify any article/provision of this Collective Bargaining Agreement, except as is provided for by Ohio Revised Code 4117.10(C) or as provided by a term(s) of this Agreement.

11. In the event of legislative action by the Ohio General Assembly that impacts in any way on this topic matter, the parties to the Master Agreement agree to reconvene bargaining to make the appropriate adjustments.

R. Labor Management Committee (LMC)

1. The Administration and the Association agree to establish a Labor Management Committee (LMC) that shall meet by the end of September of each year to discuss and determine agenda items, including training.

2. The LMC shall consist of no more than four (4) representatives from the Administration and the Association, which must also include a minimum of one (1) educational support person. The parties may mutually agree that additional persons may attend a specified session.

3. The LMC's main functions shall be: to communicate on all matters of mutual concern, to keep one another informed of changes and developments caused by conditions other than those covered by this contract, to maintain efficiency, and to resolve potential problems. It is recognized that all concerns should first be addressed at the lowest possible Administrative level and through the Association.

4. LMC meetings are intended to be informal. In an effort to maintain an atmosphere of free exchange of ideas and concerns, formal minutes shall not be kept; however, any agreements and/or recommendations reached shall be reduced to writing. Each month, the Administration will provide a written response to issues raised by the Association the preceding month, and the Association will provide a written response to issues raised by the Administration the preceding month.

5. There shall be a regularly scheduled monthly meeting of the LMC. Either party may request that the LMC meet to discuss matters of concern.

ARTICLE V

## V. EDUCATIONAL SUPPORT PERSONNEL CONDITIONS

The normal workday shall be a maximum of eight (8) hours which shall include a minimum one-half (½) hour duty-free lunch period. The normal work week shall be a regularly scheduled five (5) day period.

### A. Overtime Payment

An Educational Support Person who is scheduled by their supervisor(s) to work beyond the scheduled workday shall be granted compensatory time off or paid overtime in accordance with the following:

1. Work in excess of forty (40) hours in a normal work week, as defined above, shall be paid at one and one-half (1½) times the employee's hourly rate. The forty-hour total does not include vacation, sick leave, personal leave, holiday, or paid non-work day hours.

2. Compensatory time off is granted by the educational support person's immediate supervisor on a time and one-half basis at a time mutually convenient to the employee and the supervisor within one hundred eighty days after the overtime is worked.

### B. Paid Holidays for Educational Support Personnel

1. All regular educational support personnel employed on a 260 day contract are entitled to the following holidays for which they shall be paid their regular rate of pay, provided each such employee accrued earnings on his next preceding and his next following scheduled work days before and after such holiday or was properly excused from attendance at work on either or both of these days:

   New Year's day
   Martin Luther King day
   Memorial day
   Independence day
   Labor day
   Thanksgiving day
   Christmas Eve
   Christmas day

2. All regular full-time educational support personnel employed on a 188, 190, or 200-day contract are entitled to the following holidays for which they shall be paid their regular rate of pay provided each such employee accrued

earnings on his next preceding and his next following scheduled work days before and after such holiday or was properly excused from attendance at work on either or both of these days:

New Year's day
Martin Luther King day
Memorial day
Labor day
Thanksgiving day
Christmas day

3. All regular full-time educational support personnel employed less than nine months shall be entitled to a minimum of those holidays enumerated above which fall during the employee's time of employment.

C. Vacation for Educational Support Personnel

1. Each full-time educational support personnel after service of one (1) year with the Board shall be entitled, during each year thereafter, while continuing in the employ of the Board, to vacation leave with full pay for a minimum of two (2) calendar weeks, excluding legal holidays.

2. Full-time educational support personnel with less than one (1) year of service shall be allowed, while continuing in the employ of the Board, to take vacation time in their first year as long as they have enough vacation time accrued to meet the request.

3. Full-time educational support personnel continuing in the employ of the Board for eight (8) or more years of completed service shall be entitled to vacation leave with pay for a minimum of three (3) calendar weeks, excluding legal holidays.

4. Full-time educational support personnel continuing in the employ of the Board after fifteen (15) years of service, shall be entitled to an additional vacation day for each additional year of service each year until they get to twenty (20) years of service. Twenty (20) days is the maximum vacation for full-time classified staff.

5. Upon separation from employment a full-time educational support personnel shall be entitled to compensation at their current rate of pay for all lawfully accrued and unused vacation leave to his credit at the time of separation, not to exceed the vacation leave accrued to his credit for the two (2) years immediately preceding his separation and the prorated portion of his earned but unused vacation leave for the current year.

6. In the case of the death of a full-time educational support personnel, such accrued and unused vacation leave and prorated portion for the current year shall be paid in accordance with section 2113.04 of the Revised Code, to his estate.

7. For purposes of this section, a full-time educational support person is a person who is in the service for not less than eleven (11) months in each calendar year.

8. Eligible educational support personnel shall arrange approval for vacations through their immediate supervisor. Requests for vacation shall be submitted to the employee's immediate supervisor at least fifteen (15) days prior to the vacation. However, prior notice may be waived by the immediate supervisor. The immediate supervisor may deny requests which specify time off during the peak work period for that department or conflict with previously scheduled vacation requests. In such cases, the employee will be asked to arrange vacation at some other time during the year.

9. If an educational support person takes a vacation during a period when a holiday identified in this Agreement falls on a scheduled work day, that holiday is not chargeable against the employee's vacation days. Five (5) work days constitute one (1) weeks' vacation.

D. Hiring, Vacancies and Transfers of Educational Support Personnel

1. Hiring

a. All hiring of educational support personnel for the District shall be by the Board upon the recommendation of the Superintendent.

b. Current educational support personnel interested in new or vacant positions may request consideration for such positions in writing to the Superintendent within fourteen (14) days of the posting date.

2. Vacancies

a. A vacant position exists when the Board determines it is necessary to fill a position. A vacancy may occur for any of the following reasons:

- An employee's leaving employment as a result of a termination, resignation, retirement, or death.
- An employee's transfer to another position.
- The creation of a new bargaining unit position.

b. All vacancies and newly created positions within the classification of the bargaining unit shall be posted for fourteen (14) days prior to filling the position. Said postings will be in the form of "Notices of Vacancy" and be posted on the District's website and emailed to all employees.

c. Notices of vacancy will set forth the classification, performance expectations, qualifications, conditions of employment, location, last day to apply and procedure for making application for the new or vacant position.

3. Transfers

a. A transfer shall be defined as a change in position within a specific classification or a change from one classification to another.

b. A voluntary transfer shall be defined as an employee initiated request to transfer. Employees shall have seven (7) days after the posting date of a vacancy to request a voluntary transfer by submitting an application for the new or vacant position.

c. An involuntary transfer shall be defined as a Board initiated transfer. There will be a meeting of the employee involved and the Superintendent or his/her designee to explain the circumstances of the transfer prior to the transfer occurring.

ARTICLE VI

## VI. LEAVE PROVISION

### A. Sick Leave Policy

A bargaining unit member may be absent from duty for short periods of illness without requesting leaves of absence. The employee must notify the Principal of the absence so that substitute service can be properly arranged.

### B. Sick Leave

1. Each member will receive fifteen (15) days sick leave per year at the rate of one and one-fourth (1¼) days for each month of service under contract, twelve (12) months per year. Members who work less than full-time will receive full sick leave credit at the proportional rate of their employment.

2. New members and returning members who have exhausted their accumulated sick leave days shall be advanced (as needed) up to fifteen (15) days of sick leave. Said advancement will be repaid at the rate of one and one-fourth (1¼) days per month until the advancement has been fully reimbursed. Should a member leave the employment of the Board prior to repaying the advancement, a per diem amount will be deducted from the final pay of said member for the number of days owed.

   The Board will continue to pay the premiums for all insurance benefits called for by this Agreement for any member who has exhausted his/her sick leave accumulation and advance as agreed to in this section and who remains under active contract status with the Board.

3. The cumulative number of days of sick leave a member may accrue shall be two hundred eighty (280) days.

4. Member(s) transferring to the employment of the Board from other public school(s) or public employment in Ohio shall be permitted to transfer accrued sick leave up to two hundred eighty (280) days.

5. Members may use sick leave, upon approval of the administration for absence due to illness, pregnancy, injury, exposure to contagious disease which could be communicated to other employees, and for illness, injury, or death in the member's immediate family.

6. Regarding illness or injury, the member's immediate family shall include: spouse, children (including step), parents (including step), siblings (including step), in-laws (including step), legal guardians and foster

children. Regarding death, the member's immediate family shall include: spouse, children (including step), parents (including step), siblings (including step), in-laws (including step), aunts, uncles, nieces, nephews, grandparents, grandchildren regardless of residence, legal guardians and foster children.

7. The Board may require a member to furnish a written, signed statement to justify the use of sick leave.

   If medical attention is required, the statement shall list the name and address of the attending physician and the dates when he/she was consulted. Nothing in this section shall be construed to waive the physician-patient privilege provided by Section 2317.02 of the Ohio Revised Code.

8. A maximum of three (3) unused personal leave days may, at the option of the member, be used as sick leave days by informing the Superintendent's Office by written request, of the desire of the member to do so. The three (3) days are all unrestricted except before and after holidays and should remain as such. All other provisions of personal leave will remain as the same.

C. Sick Leave Transfer Program

1. The Sick Leave Transfer Program is designed to assist members who experience a serious accident or major illness for which they do not have adequate sick leave as provided under Article VI, Section B. A committee shall be set up of two (2) Board representatives designated by the Superintendent and two (2) Association representatives designated by the Association President in order to set up a procedure for the operation of this donation.

2. To be eligible a member must have used all available sick leave. The amount of sick leave awarded per person per year under this program shall not exceed thirty (30) days or the number of days remaining in that current school year, whichever is less.

3. Emergency sick leave shall be approved for all members who have:

   a. exhausted all available sick leave;

   b. submitted an application to the Treasurer's Office; (Appendix P)

   c. presented a physician's certificate indicating a single illness or injury due to an accident of the member or the member's immediate family will last, or exceed 20 consecutive days, that the member is

unable to perform all contractual duties (a second opinion may be required), and if possible specify the period of time that will be necessary for recovery. Regarding the Sick Leave Transfer Program, the member's immediate family shall be defined as spouse, children, stepchildren and/or foster children.

4. The sick leave transfer pool is formed from the contribution of up to five (5) day(s) per year of accumulated sick leave from each member who wishes to voluntarily participate. The pool will not exceed one-hundred (100) days at any one time. Unused days in the sick leave pool shall be carried over to the next school year. Once a day has been transferred to the pool, it cannot be withdrawn. (Appendix O)

5. Members are not eligible to be granted sick leave transfer days if:

   a. it is routine maternity;

   b. the specific injury or illness is not 20 consecutive days or more;

   c. they are approved for STRS/SERS disability.

D. Personal Leave

Verbal requests for personal leave, if presented to the Superintendent in the case of an emergency which prohibits the request to be submitted through kiosk, shall be granted. Verbal requests for personal leave shall be submitted through kiosk immediately upon return from the absence.

Three (3) days of personal leave shall be unrestrictive as to reason except as specified below. The number of educational support personnel on personal leave at the same time shall be limited to two (2) in the same classification.

Other absences without pay not covered by these rules and regulations may be authorized by the Superintendent.

Absences not acceptable for paid leave will include:

1. Leave the day before or after a holiday or during examination time.

2. Leave during the last fifteen (15) school days of the school year unless such leave is requested and approved for one of the following reasons and is supported by appropriate written documentation:

   a. Medical
   b. Legal

c. Religious
d. Graduation
e. Honors convocation
f. Real estate transaction
g. Moving
h. Death of a close friend
i. Participation in a wedding
j. Educational requirements
k. Necessary personal or family business
l. Emergency

E. Perfect Attendance Incentive

1. In each school year, and upon submission of a written request by the member to the Treasurer no later than June 30th of each year, the Board will pay $95.00 for each unused personal leave day

2. Unused Sick Leave

a. In each school year that a member does not use any sick days, the member will receive Two Hundred and Eight Five Dollars ($285.00).

b. If only one (1) sick day is used in the school year, then the member shall receive One Hundred and Ninety Dollars ($190.00).

c. If only two (2) sick days are used in the school year, then the member shall receive Ninety-Five Dollars ($95.00).

3. Payments made under this provision shall be included in the second (2nd) pay in July of each school year, and shall be made upon the member's submission of a written request to the Treasurer no later than June 30th of each year.

4. Educational Support Personnel who are employed on twelve-month contracts shall be eligible for the above bonus plus an additional bonus of $100 if, in addition to perfect attendance during the school year, no personal days or sick leave days are used during the summer (regular scheduled work days after the last and before the first student day). Payment of this additional bonus shall be included in the second (2nd) pay in September.

5. Professional Leave, Jury Duty and Vacation Leave shall be treated the same as a "regular day worked" for the Perfect Attendance Incentive only.

F. Absence on School Business

Permission may be granted, by the Superintendent, to personnel to visit other schools or attend to school.

G. Leave of Absence

1. Upon written request, a member shall be granted a leave of absence without pay for illness or other disability and may be granted such leave for educational, professional, or other purposes. Such leave shall be a maximum of one (1) year. Upon subsequent request, such leave may be renewed. At least forty-five (45) days prior to the expiration of the leave the Superintendent may request the member to indicate their intent by written notification.

2. A written letter of application must be made to the Superintendent at least forty-five (45) days prior to the effective date of the leave. This requirement will be waived in cases of emergency.

3. Members of the bargaining unit who take any leave under this section shall be eligible to continue in Board-provided insurance plans up to a period of twelve (12) months by paying the regular premiums to the Treasurer prior to the due date.

4. At the expiration of the approved leave, the member shall resume the contract status which he/she held prior to such leave. The returning staff member shall be granted his/her position held prior to the leave, if the approved leave did not exceed one (1) year and the position is still in existence. If the said position has been abolished, the returning staff member shall be appointed to an equivalent certificated position for which he/she is certified to teach, or in the event of a bargaining unit educational support staff personnel, an equivalent position for which he/she is qualified. This shall be done in accordance with seniority.

5. Unrequested leaves of absence for reasons of illness or other disability may be granted and shall be in accordance with Ohio Revised Code 3319.13, 3319.16, and 3319.161.

6. Sick leave shall not accrue during times of unpaid leave status.

H. Maternity/Paternity Leave

1. Leave Privileges

In addition to the provisions of sick leave provided in Section A, a member who is pregnant or adopts a child shall, upon request, be granted a leave of absence without pay for maternity/paternity reasons. Such leave shall begin at a time between the onset of pregnancy and the delivery of the child, or if adoption, receipt of custody, and to continue up to one (1) year after the child is born or custody is received. This leave period may be renewed upon application for extension.

If the member so elects, a maternity/paternity leave may begin when the sick leave expires or is terminated, if applicable.

2. Application for Maternity/Paternity Leave

Applications for maternity/paternity leave shall state in writing:

a. Expected date of birth or custody

b. Date requested leave is to commence

c. Date member expects to return to service

d. Name of physician or adoption official

3. Time Period for Filing Application

Application for maternity/paternity leave should be made forty-five (45) days, if possible, but not less than thirty (30) days, prior to the requested beginning of maternity/paternity leave or extension of same. The application time period will be waived for adoption and other emergency situations.

At least forty-five (45) days prior to the expiration of leave, written notification of the intentions of the member on leave could be requested by the Superintendent.

4. Benefits While on Leave

Sick leave shall accrue during maternity/paternity leave if using sick leave.

Members on maternity/paternity leave may continue to participate in employee Board-paid group benefits provided they furnish the Treasurer with the necessary premium payments in advance of when they are due.

5. Reinstatement

Upon return from approved maternity/paternity leave, at the time specified in the application, the member shall be entitled to reinstatement to the same position which he/she held prior to the leave if the leave did not extend beyond one (1) consecutive school year and the position is still in existence. If the said position has been abolished, the returning teacher shall be appointed to an equivalent certificated position for which he/she is certified to teach or, in the event of educational support staff personnel, an equivalent position for which he/she is qualified. This shall be done in accordance with seniority.

ARTICLE VII

## VII. PROFESSIONAL GROWTH

### A. Professional Growth

The Board recognizes that the impact members have on students can be greatly increased through member growth opportunities outside the classroom.

The Superintendent shall offer the staff opportunities in areas such as the following:

1. Released time and leaves of absence for travel and study.

2. Visits to other classrooms and schools.

3. Participation in professional conferences.

4. Training in classes and workshops.

5. Further training in colleges and universities.

The administrative staff will be responsible for rules and regulations concerning the above.

### B. Attendance at Professional Meetings

The Superintendent may recommend employees to attend professional meetings which, in his judgment, will prove beneficial.

### C. In-Service

The membership will be given the opportunity to offer suggestions to the administration for programs for in-service days which are a part of the regular school calendar or other non-scheduled in-service days. When committees are formed to work on in-service programs, member representation to the committee(s) will be secured through the Association President.

### D. CDL Bus Endorsements / Commercial Pesticide License

CDL bus endorsement training and commercial pesticide license training will be supported by the district at 100% of the cost for members who receive prior approval by the Superintendent, based upon need. Recertification costs will also be reimbursed at 100% upon completion.

E. Tuition Reimbursement For Teachers

1. The Board shall appropriate $15,000 per year for the purpose of tuition reimbursement.

2. These funds will be distributed to teachers and to teachers on a temporary license taking courses from an accredited institution in the area of the teacher's certification(s) or related area, or for advanced educational degrees or certificates or for Resident Educator courses. In order to receive tuition reimbursement, a grade of "B" or higher must be received, or if no grades are offered, a designation of satisfactory must be received.

3. The monies will be divided among teachers who successfully complete courses at accredited colleges and universities based on a semester credit hour prorated amount (1½ quarter hours = 1 semester hour) during the time period August 1st - July 31st of each year. A teacher who earns college credit shall be reimbursed to a maximum of one hundred seventy-five dollars ($175.00) per semester hour (tuition only) or a maximum of eighty-three ($83.00) per quarter hour (tuition only). A maximum of twelve (12) semester hours or eighteen (18) quarter hours will be reimbursed per teacher. Hours reimbursed must reflect an out-of-pocket expense to the teacher. An "Application for Reimbursement for College Credit" must be submitted and approved by the LPDC.

4. In order to receive reimbursement teachers shall submit a grade transcript or documentation indicating successful completion and written receipts for appropriate expenditures to the Treasurer by October 1st.

5. Teachers will receive no more than costs of such courses taken during the aforementioned time period which shall include costs for tuition required. If there is no tuition charge, costs for fees, required books and/or materials will be prorated on a ratio of $250 per semester hour.

6. Teachers will be reimbursed for their classes on or before October 31st of each school year.

7. A report of the usage of tuition reimbursement shall be given to the AVTA President by December 1st of each year.

ARTICLE VIII

## VIII. SALARY AND FRINGE BENEFITS

### A. Teacher Salary Schedule

1. The Board respects the concept of a single salary schedule, whereby equal training and experience regardless of area or subject taught, or sex of the teacher.

2. The salary schedule is understood to represent the appropriate compensation that each member of the bargaining unit shall be entitled to for performing responsibilities that are within the scope of that unit definition. Placement on the schedule shall be in accordance with the Ohio Revised Code. Said members shall not be required to perform such services for more than one hundred eighty-three (183) days in any school year and such days shall be in accordance with the Board adopted school calendar. Each work day shall not exceed seven hours. Should a member be required and agree to work more than seven (7) hours in any day and/or, one hundred eighty-three (183) days in any year and such work is not included in the supplemental pay schedule, said member will be paid additional compensation in the amount of the member's regular salary per day rate (salary/183) divided by seven (7 hours per day) times the additional hours worked.

### B. Teacher Salary

The BA Base salary will be as follows:

1. Effective August 1, 2017 – July 31, 2018, the base salary shall be thirty-four thousand, nine hundred and sixty-one dollars ($34,961).

2. Effective August 1, 2018 – July 31, 2019, the base salary shall be thirty-five thousand, six hundred and twenty-nine dollars ($35,629).

3. Effective August 1, 2019– July 31, 2020, the base salary shall be thirty-six thousand and seventy-four dollars ($36,074).

4. The Base salary (Category I - Step 0) shall be applied to the index agreed upon in Appendix Q.

5. Salary Index - See Appendix Q.

6. Salary Schedule – 2017 - 2018 See Appendices R, S and T.

7. Salary Schedule – 2018 - 2019 See Appendix S.

8. Salary Schedule 2019 – 2020 See Appendix T.

C. Payment of Salary - Teachers

The first installment of each teacher's salary shall begin with the first payroll in September of each school year.

However, any newly hired teacher, in their first contract year only, shall be given the option to have their annual salary paid in twenty-five (25) installments. Should the newly hired teacher select this option in their first year, it is understood that their first installment of salary would begin with the last pay in August of that year. It is further understood, in the second contract year and thereafter of any newly hired teacher that selected this option, the annual salary shall be paid in twenty-four (24) installments with the first installment to begin in September of that school year.

D. Index Attached

Index for 2018-2020 is in Appendix Q. This index will remain in effect the length of the contract.

E. Supplemental Salaries

1. Any teacher performing at least four (4) activities listed in the supplemental pay schedule will be compensated according to the Supplemental Salary Schedule. Contract(s) shall be approved within sixty (60) days of the beginning of the school year of the effective date of the contract (i.e., in October 2017 for the 2017-2018 school year).

2. Individual members will be compensated based on completion of organizational activities. Movement upon the Schedule Steps below will be based upon individual members completing at least four activities of those listed or equivalent activity.

3. Between negotiation times, additional activities and their supplemental salary may be added to this schedule by mutual consent of the Association and the Board.

4. Teachers shall not be required to accept a supplemental responsibility(ies) and the execution of an appropriate contract.

5. Period of assignment of additional duty shall appear on the supplemental contract as well as the compensation and payment plan.

6. Supplemental Salary Schedule (Index number to be applied to the BA - Step 0 amount).

SUPPLEMENTAL ORGANIZATION

| | STEP 1 | STEP 2 | STEP 3 |
|---|---|---|---|
| | #NUMBER OF ACTIVITIES | | |
| ORGANIZATION | 4-7 | 8-11 | 12 or more |
| Family Career & Community Leaders Of America | .015 | .025 | .030 |
| Skills USA* | .015 | .025 | .030 |
| Health Occupation Students of America (HOSA) | .015 | .025 | .030 |
| FFA | .015 | .025 | .030 |
| Student Leadership (Interact) Advisor | .015 | .025 | .030 |

PROJECT COORDINATOR SUPPLEMENTALS

| | |
|---|---|
| Yearbook Coordinator | $400.00 |

*The number of General Skills USA Lead Advisors is limited to no more than three (3) bargaining unit members.

| | |
|---|---|
| Summer Camp Certified Instructor | $1,000 |

7. Appendix BB contains a compilation of activities from the various Career Technical Student Organizations. The member should submit documentation of activities to his/her Supervisor for qualification of advancement on the step index. The Documentation Guidelines are found in Appendix CC. Format for meeting minutes are found in Appendix DD.

F. Educational Support Personnel Salary Schedules

1. The hourly rate schedule and index for educational support personnel from August 1, 2017 through July 31, 2020 shall be found in Appendix V thru Appendix Z.

G. Payment of Salary - Educational Support Personnel

The annual salary of educational support personnel shall be paid in twenty-four (24) installments.

Any newly hired educational support personnel, in their first contracted year only, shall be given the option to have their annual salary paid in twenty-five (25) installments. Should the newly hired educational support personnel select this option in their first year, it is understood that in the second contract year and thereafter, the annual salary shall be paid in twenty-four (24) installments starting in August and each year thereafter.

H. Insurance Program

1. The Board shall provide medical, prescription drug, dental, and vision benefits through a carrier licensed by the State of Ohio for each member and their dependents that enroll. Should the Board select a different benefit provider, coverage must meet or exceed the specifications outlined in the Schedule of Comprehensive Major Medical Expense Benefits attached as an appendix to this contract (Appendix AA). The summary plan document and contract of the plan is incorporated herein by reference.

   a. The Board shall maintain the current insurance plan for all bargaining unit members that are employed by the District as of June 30, 2018.

   b. For new employees hired after June 30, 2018, bargaining unit members shall have two (2) insurance plans to choose from as follows:
      i. $1,500 Alternative Plan
      ii. $3,000 H.S.A. Plan

2. For the 2017-2018 school year, the Board shall pay ninety percent (90%) of all individual, individual plus one or family benefit premium and the Employee shall pay ten percent (10%).

   For the 2018-2019 and 2019-2020 school years, the Board shall pay eighty-eight percent (88%) of all individual, individual plus one or family benefit premium and the Employee shall pay twelve percent (12%).

   For the 2018-2019 and 2019-2020 school years, employees shall have the Wellness Incentive Options that are set forth in Appendix HH which will allow them to decrease their contributions to a maximum of ten percent (10%) by earning any combination of the wellness credits (for the $250 Deductible Plan and/or $1,500 Deductible Plan).

The Board shall implement a Section 125 Premium Only plan.

3. Underwriting Guidelines

a. Eligibility Window

The enrollment provisions of each member's plan of benefits must limit enrollment to occur within 31 days of the initial eligibility date.

In case of birth or adoption, enrollment must occur within 90 days of the initial eligibility date.

b. Late Entrants

If an Employee or dependent fails to enroll within thirty-one (31) days of becoming eligible, he will not be eligible for coverage unless he is a special enrollee under HIPAA requirements, or unless it is during the open enrollment period. In the event that an Eligible Employee or Eligible Dependent does not enroll within 31 days of the date of eligibility, he may complete enrollment during the annual open enrollment period (which is the month of May of any year) and coverage will be effective on the next following July 1st.

A person is eligible to enroll in the Plan if (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or (2) the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days. Such coverage will be effective on the day following the date coverage is lost under Medicaid or CHIP.

c. Change in Family Status

Changes in family status for which a benefit election change may be permitted include the marriage or divorce of the Eligible Employee; the death of an Eligible Employee's spouse or an Eligible Dependent; the birth or adoption of a child of the Eligible Employee; the termination of employment (or the commencement of employment) of the Eligible Employee's spouse; the switching from part-time to full-time employment status or from full-time to part-time status by the Eligible Employee or the Eligible Employee's spouse; or the taking of an unpaid leave of absence by the Eligible Employee or Eligible Employee's spouse. Election changes are also

permitted where there has been a significant change in the health coverage of the Eligible Employee, spouse, or ex-spouse attributable to the spouse's or ex-spouse's employment. Benefit election changes are consistent with family status changes only if the election changes are necessary or appropriate as a result of the family status change.

d. Plan Maximums

See Schedule of Comprehensive Benefits –Appendix AA.

e. Participation Requirements

Employees working fewer than 30 hours per week shall not be eligible for coverage under the plan of benefits.

4. Term Life Insurance

The Board shall provide each member with a term life insurance policy providing for 1) a death benefit of fifty thousand dollars ($50,000.00) and 2) an additional benefit of fifty thousand dollars ($50,000.00) based upon accidental death and dismemberment coverage. Such insurance shall be purchased through a carrier licensed by the State of Ohio and shall be at no cost to the member

5. General Provisions (Copies may be provided electronically through the Board website.)

a. Copies of Benefit Contract

The Board shall provide the Association President with one (1) copy of each signed contract entered into between the Board and Insurance Company(ies) which provides the benefits(s) specified in this Agreement. Copies of existing contract(s) shall be provided to the Association within twenty-four (24) hours of ratification of this Agreement by both parties. Copies of contracts subsequently entered into by the Board shall be provided to the Association within one (1) week after they are received by the Board.

b. Copies of Benefit Descriptions

Within thirty (30) days of the effective date of this Agreement, the Board shall provide each member with a written description, prepared by the carrier, of each insurance plan provided by this Agreement.

c. Benefit Description for New Members

A member employed after the effective date of this Agreement shall be provided, at the time of employment, with a written description prepared by the carrier, of each insurance plan that provides benefits specified by this Agreement.

d. Copies of Improvements in Existing Benefits

Within thirty (30) days of the effective date of any improvement(s) in an insurance plan provided by this Agreement, each member shall receive a written description prepared by the carrier, of the improved plan.

I. Mileage

Mileage will be paid at the maximum allowed by the Internal Revenue Service, in performance of authorized Board business.

J. Overnight Assignments

When a member has been assigned by the administration as a part of their regular teaching duties to take part in an overnight trip as required by the Vocational Student Organization activities, that member shall receive one hundred dollars ($100) per night in addition to the member's regular salary. The necessity for the overnight assignment shall be determined and preapproved by the secondary principal.

K. Severance Pay

All members employed by the Board who retire from regular employment shall receive one (1) severance payment which shall be considered a retirement stipend and shall be limited to fifty percent (50%) of the members total accumulated sick leave balance at the time of retirement, to a maximum of sixty-five (65) days. However, a member may be eligible for additional days in accordance with Article III. S. The payment shall be calculated based upon the member's daily rate of pay during his/her final year of teaching for teachers, or final year of work for educational support personnel, conditioned upon the member actually making application and accepting retirement from the State Teachers Retirement System or the School Employees Retirement System, and receiving benefits therefrom, and further conditioned upon the fact that the member accepts this stipend in lieu of all accumulated sick leave benefits of record. Payment will be made within (30) days of submission of a STRS/SERS Retirement Acceptance Letter and/or a copy of a retirement check or direct deposit receipt from the retiree.

L. Payroll Deductions

Payroll deductions available for those who wish to enroll in tax sheltered annuities (TSAs).

M. STRS/SERS Pick-up

The Board agrees to the "Pick-Up" system (non-pay 10.0% SERS, non-pay 14% STRS) of contributions to the State Teachers Retirement System or the School Employees Retirement System, whichever is applicable.

1. The Board shall compute and remit all applicable contributions to STRS/SERS based upon annual salary and/or earned compensation which includes the amount of the "pick-up" computed herein.

2. For IRS purposes only, annual compensation listed on the W-2 form shall be the bargaining unit member's annual compensation reduced by 10.0 % and 14% respectively.

N. Teacher Salary Schedule Placement Related to Training

Placement on the salary schedule for training will be as follows:

| | |
|---|---|
| 1. B.A. Column - | Meeting minimum requirements of State Department of Education for a temporary, provisional or alternative resident educator vocational certificate/license; or a B.A. degree with a temporary, provisional or resident educator vocational certificate/license; or a B.A. degree with resident educator license. |
| 2. 135 Hrs. (B.A. + 10) - | No college degree with a professional vocational certificate/license and completion of at least ten (10) semester hours of additional training from an accredited college, university, or other related vocational course work taken at other than a college or university after initial placement on the B.A. column; or B.A. degree with at least 135 college level semester credits from an accredited college or university after initial placement on the B.A. column. |
| 3. 150 Hrs. (B.A. + 25) - | No college degree with a professional vocational certificate/license and completion of at least twenty-five (25) semester hours from an accredited college, university, or other related vocational course work taken at other than a college or university after initial placement on the B.A. column; or B.A. degree with at least 150 college level semester credits from an |

| | | |
|---|---|---|
| | | accredited college or university after initial placement on the B.A. column. |
| 4. 175 Hrs. (B.A. + 50) | - | No college degree with a professional vocational certificate/license and completion of at least fifty (50) semester hours from an accredited college, university, or other related vocational course work taken at other than a college or university after initial placement on the B.A. column; or B.A. degree with at least 175 college level semester credits from an accredited college or university after initial placement on the B.A. column. |
| 5. M.A. Column | - | M.A. degree; or B.A. degree (if earned after obtaining a professional vocational license). |
| 6. M.A. + 10 Column | - | M.A. degree with at least ten (10) semester hours of additional training from an accredited college or university after placement on the M.A. column has been achieved; or B.A. degree (if earned after obtaining a professional vocational license) with at least ten (10) semester hours of additional training from an accredited college, university, or other approved vocational related courses taken at other than a college or university after placement on the M.A. column has been achieved. |
| 7. M.A. + 20 Column | - | M.A. degree with at least twenty (20) semester hours of additional training from an accredited college or university after placement on the M.A. column has been achieved; or B.A. degree (if earned after obtaining a professional vocational license) with at least twenty (20) semester hours of additional training from an accredited college, university, or other approved vocational related courses taken at other than a college or university after placement on the M.A. column has been achieved. |
| 8. M.A. +30 Column | - | M.A. degree with at least thirty (30) semester hours of additional training from an accredited college or university after placement on the M.A. column has been achieved; or B.A. degree (if earned after obtaining a professional vocational license) with at least thirty (30) semester hours of additional training from an accredited college, university, or other approved vocational related courses taken at other than a college or university after placement on the M.A. column has been achieved. |
| 9. M.A. +40 Column | - | M.A. degree with at least forty (40) semester hours of additional training from an accredited college or university after placement on the M.A. column has been achieved; or B.A. degree (if earned after obtaining a professional vocational license) with at least forty (40) semester hours of additional training from an accredited college, university, or other |

| | | |
|---|---|---|
| | | approved vocational related courses taken at other than a college or university after placement on the M.A. column has been achieved. |

O. Experience Credit on Salary Schedule (Teachers)

1. Teachers will receive full credit for all teaching experience and military experience as specified in the Ohio Revised Code, or other employment experience related to the area for which he/she has been hired to a maximum of ten (10) years. However, the Superintendent may in his/her discretion exceed the maximum teaching experience specified in the Ohio Revised Code.

2. A "year of experience" shall be one hundred twenty (120) or more days of employment as a teacher within any school year or two hundred (200) or more days of employment in a work related area within any calendar year.

P. Salary Reclassification (Teachers)

Salary changes due to graduate or undergraduate credit hours, or other approved vocational related courses from other than a college or university obtained by each teacher during the spring and summer shall be made upon the submission of a transcript and written request to the Treasurer by October 15th of that year and any increase in pay shall be retroactive to the first day of the contract of that year.

Salary changes for graduate or undergraduate credit hours, or other approved vocational related courses from other than a college or university obtained by each teacher during the fall and winter shall be made upon the submission of a transcript and a written request to the Treasurer by March 1st of that year. Any increase in pay shall be retroactive to January 1st of that year.

Q. Representation

Each member of the bargaining unit shall have the right to Association representation when a meeting or conference is held with management when the purpose of the meeting or conference is related to a provision of the Agreement, other terms and conditions of employment, or has disciplinary ramifications.

R. OX Agreement - Vocational Teachers

Supplemental contracts for assigned instructional time of (300) or more minutes daily.

Vocational teachers assigned to teach two full laboratory periods (a.m. and p.m.) of at least 150 minutes each will receive extra compensation in the first pay in November.

- The vocational teacher would receive compensation in a supplemental contract for the following:

| Student Numbers | Stipend |
|---|---|
| 10-18 | $1,500.00 |
| 19-20 | 2,000.00 |
| 21-22 | 2,500.00 |
| 23-24 | 3,000.00 |
| 25+ | 3,500.00 |

The stipend shall be based upon the number of students during the first full week of October. This stipend shall be paid evenly from the first pay in November through the remaining pays of the contract year.

Vocational teachers with combined labs (juniors and seniors) due to insufficient enrollment to operate separate labs may request in writing to the Superintendent by April 1st to be placed in the separate lab format for the next school year. The written request from the vocational teacher must specify that enrollment for the next school year will meet and/or exceed the guidelines stated above by the first day of school in the next school year.

The guidelines as specified above will be followed for the vocational teacher from the first day of school until the first full week of October for supplemental contract compensation consideration.

This supplemental contract/compensation is provided in lieu of the vocational teacher receiving the full conference period each day.

It is the intent of the Board to implement this section through staff attrition and/or expanded enrollment in vocational programs as they meet the guidelines as stated above. The Board shall not utilize Reduction in Force (RIF) to implement this section.

S. Enrollment Incentive

Because the recruitment and retention of students is a school wide effort, the following incentive shall be applied to all bargaining unit member:

| Year | ACWHCC Oct. Building Enrollment | November Payment | ACWHCC Feb Building Enrollment | March Payment |
|---|---|---|---|---|
| Certified | 375 | $300 | 375 | $300 |
| ESP | 375 | $150 | 375 | $150 |

Eligibility for the incentive payment(s) will be determined twice annually based on student enrollment as of the first Wednesday of October and the first Wednesday of February of each school year. If the incentive is met in October, each bargaining unit member will receive one half (½) the incentive amount. Furthermore, if the incentive is met in February, each bargaining unit member will receive one half (½) the amount.

Incentive payments will be made with the first pay in November and the first pay in March to those eligible.

T. Employment of Retirees

While the Board is under no obligation to employ any retired person to fill a bargaining unit position and the parties agree that there is no expectation of continued employment or re-employment when a bargaining unit member resigns for purposes of service retirement from the employment of the Board, the Board reserves the right to employ individuals in bargaining unit positions who have retired to STRS or SERS on the following basis:

1. A retiree shall receive a one-year limited contract, which shall expire automatically at the end of the stated term. No notice of non-renewal or Board action is required. Continuation of the employment of a retiree through offering new one-year limited contracts, which automatically expire, shall be at the election of the Board and upon recommendation of the Superintendent. The requirements of Article III, Section H and J regarding limited contracts and non-renewals shall not apply to retiree limited contracts. Likewise, a retiree is not eligible for a continuing contract, regardless of years of employment with the Board. The parties specifically waive all rights for such employees provided under O.R.C. Sections 3319.081, 3319.083, 3319.11 and 3319.111.

2. Upon re-employment, a retired bargaining unit member shall be placed on the salary schedule at CAT 4, Step 10 for teachers and Step 10 of the appropriate salary schedule for the employee's classification for educational

support personnel. If such retiree is granted a second one-year limited contract, he/she shall then be placed on the salary schedule at CAT 4, Step 10 for teachers and the Step 10 of the education support personnel salary schedule. If such retiree is granted additional one-year limited contracts after the second such contract, he/she shall continue to be placed (locked-in without future increases) at this level. This provision and such salary and individual employment contract with the reemployed bargaining unit member expressly supersedes O.R.C. Sections 3319.081, 3319.082, 3317.13 and 3317.14, and all other applicable laws.

3. A retiree shall be entitled to accrue sick leave once re-employed. However, upon initial employment under this article, retirees shall be credited with zero (0) days of sick leave accumulation. Further, retirees shall not receive credit for any previously accumulated sick leave from any public service. This provision shall specifically supersede O.R.C. Section 3319.141.

4. A retiree shall not be eligible for severance pay under Article VIII, Section (K) of the Master Agreement or under Ohio statutory law upon leaving the employment of the Board.

5. Further, retirees shall not enjoy any rights under the following Articles of the Master Agreement- Article III, Sections (O) and (P) - Reduction In Force, Article IV(A) or Article (V)(D) - Assignments and Transfers, Article VII- Professional Growth, Article VI(H) Maternity/Paternity Leave. In addition, retirees covered under this Article are not eligible for participation in the Sick Leave Transfer Program – Article VI(C).

6. Retirees shall be eligible to receive any insurance benefits provided for other bargaining unit members during his/her employment with the Board.

7. Reemployed bargaining unit members may not accrue additional STRS/SERS credit as a result of their service following reemployment. Instead, the Board and the reemployed member shall make contributions to STRS/SERS that will fund a single life annuity with a reserve based on the reemployed bargaining unit member's accumulated contributions during his/her period of service as a regular teacher following reemployment. For additional information concerning the annuity see, O.R.C. 3307.35.

8. Seniority for employees hired in retirement shall always be zero (0); however, bargaining unit members hired following retirement will be considered to have greater seniority than individuals hired in retirement from outside the District. No previous service time shall be used to determine seniority for purposes of a reduction in force.

9. A retiree shall be eligible for appointment to a supplemental contract only at the discretion of the Superintendent.

10. The grievance procedure contained in this Agreement may not be applied to issues in this section for which discretion is granted the Board of Education.

11. All terms, conditions, rights and responsibilities afforded to members of the bargaining unit shall apply to all retirees unless expressly stated otherwise above.

The parties further expressly agree and fully intend this Article to supersede and take precedent over any inconsistent and/or contrary provisions of the Ohio Revised Code, the Ohio Administrative Code, and federal laws and regulations.

ARTICLE IX

## IX. ASSOCIATION RIGHTS

The Ashland Vocational Teachers' Association, hereinafter "Association" as the exclusive bargaining representative for teachers and educational support staff, shall have the following sole and exclusive rights and privileges:

A. Payroll deduction of professional dues for the members of the Association to the United Teaching Professional (defined as the National Education Association, Ohio Education Association, North Central Ohio Education Association, and the Ashland Vocational Teachers' Association), shall be paid by the Treasurer and a receipt given to the AVTA Treasurer. Deductions for local AVTA dues shall be deducted and paid in the first pay in October. From the second pay in October through the last pay in June the remaining dues shall be deducted and paid to OEA.

B. Agendas, minutes, and financial statements, and other official documents or papers used in the course of the public portion of Board meetings will be made available to the Association by the Treasurer at least twenty-four (24) hours prior to the meeting. The President of the Association will be notified of the time and place of all regular and special Board meetings.

C. Association officers and/or delegates who request leave to attend Association business will be granted up to five (5) professional leave days in a school year. No more than three (3) Association members will be approved to attend the same meeting. The Association shall provide the substitute(s) necessary to fill the vacancies.

D. Use of members' mailboxes in the building to distribute Association literature.

E. Free building use for Association meetings that do not interfere with previously scheduled school activities. Notice of such requested use shall be given to the building administrator as far in advance as possible.

F. Phone use for Association business.

G. Office machines use (with adequate training by the secretarial staff so long as such use does not interfere with school business).

H. Names and department assignments of all new member staff as soon as available.

I. Financial and insurance information upon request by the Association President.

J. Announcements at staff meetings, whether department or district-wide, including new staff or district-wide orientation meeting(s) at the beginning of the school year.

K. Informal meetings with the Superintendent at the request of the Superintendent or the President of the Association.

ARTICLE X

## X. MANAGEMENT RIGHTS

Board rights, powers, duties, discretions, authority and prerogatives are retained by, and shall remain exclusively vested in the Board, except as limited by this Agreement. The Board, in the exercise of these rights, powers, authorities, duties, and responsibilities shall be consistent with constitutional provisions, Ohio Revised Code Chapter 4117.08c, Article I, Section 1.05 and Article VIII, Sections 8.01 and 8.02 of this Agreement. The Board reserves and retains full rights, authority, and discretion to control, supervise, and manage the operation of the district and to make and enforce policies, rules and regulations not inconsistent with the terms of this Agreement. The Board, however, cannot reduce, negotiate or delegate its legal responsibilities.

ARTICLE XI

XI. DURATION OF AGREEMENT

The terms and conditions of this Agreement shall be effective on August 1, 2017, and shall continue in full force and effect until twelve o'clock midnight, July 31, 2020, at which time it shall expire.

The terms and conditions as set forth in this Agreement indicate the understanding that exists between the parties to this Agreement; however, it is further agreed that nothing contained in said Agreement should be interpreted to deny the Association or its members of the bargaining unit of any rights, benefits, privileges, etc., that might be forthcoming as the result of law of the State of Ohio or interpretation(s), rulings and precedence of such laws.

In Witness Whereof, the parties executed this Agreement on the _____ day of _____, 2018.

| | | | |
|---|---|---|---|
| by: | _____, Pres. | by: | _____, Pres. |
| by: | _____, Supt. | by: | _____, Neg. |
| by: | _____, Treas. | by: | _____, Neg. |
| by: | _____, Neg. | by: | _____, Neg |
| by: | _____, Neg. | by: | _____, Neg. |

**Appendix A**

**Grievance Report Form**
(to be filed in triplicate)

Grievance # _____ Date Filed _____

Name of Aggrieved _____

Department _____ Assignment _____

LEVEL ONE
(submitted to Superintendent)

A. Date cause of grievance occurred _____

B. 1. Statement of grievance: Include specific provision(s) of Agreement alleged to have been violated.

2. Relief sought:

C. _____ _____
Signature of Aggrieved Date

D. Disposition by Superintendent:

_____ _____
Signature of Superintendent Date

LEVEL TWO
(submitted to Board of Education)

A. Position of aggrieved or Association:

_____ _____
Signature of Aggrieved Date

B. Disposition of Board of Education:

_____ _____
Signature of President of Board Date

LEVEL THREE
(submitted to Arbitrator)

A. Position of aggrieved or Association

_____ _____
Signature of Executive Committee Chairperson Date

_____ _____
Signature of Aggrieved Date

B. Disposition of the Arbitrator:

_____ _____
Signature of the Arbitrator Date

**Appendix B**

Evaluator/Observer

ASHLAND COUNTY-WEST HOLMES CAREER CENTER

Certified Non-Classroom Personnel Observation Form

Name _____ Date_____

Assignment _____

Performance Areas:

I. Professional Ability
- _____ 1. Understands work procedures
- _____ 2. Establishes priorities
- _____ 3. Develops plan
- _____ 4. Completes and follows up on assigned tasks
- _____ 5. Willing to assume responsibilities
- _____ 6. Considers all factors in making decisions
- _____ 7. Accomplishment of primary mission of position
- _____ 8. Keeps fellow staff members informed

Comments:

II. Communication
- _____ 1. Communicates effectively with fellow staff members
- _____ 2. Exhibits good oral communication skills
- _____ 3. Exhibits good written communication skills

Comments:

III. Personal Characteristics

_____ 1. Dresses appropriately for activities concerned

_____ 2. Demonstrates good problem solving techniques

Comments:

IV. Additional Comments by Evaluator:

V. Additional Comments by Teacher:

---

| | | |
|---|---|---|
| Rating Scale: | 5. | Superior (well above expected level) |
| | 4. | Excellent (above expected level) |
| | 3. | Satisfactory (meets the expected level) |
| | 2. | Below expected level (some improvement needed - improvement plan may be required, and suggestions will be included) |
| | 1. | Unsatisfactory (improvement plan required) |
| | NA | Not applicable |
| | Unmarked | Not Observed |

---

The teacher's signature indicates that all phases of the evaluation have been conducted with the full knowledge of the teacher and does not necessarily indicate agreement with the contents of the completed form.

Teacher's Signature _____ Date _____

Evaluator's Signature _____ Date _____

**Appendix C**

Evaluator/Observer

ASHLAND COUNTY-WEST HOLMES CAREER CENTER

Certified Non-Classroom Personnel Evaluation Form

Name _____ Date _____

Assignment _____

Performance Areas:

I. Professional Ability
- _____ 1. Understands work procedures
- _____ 2. Establishes priorities
- _____ 3. Develops plans
- _____ 4. Completes and follows up on assigned tasks
- _____ 5. Willing to assume responsibilities
- _____ 6 Considers all factors in making decisions
- _____ 7. Accomplishment of primary mission of position
- _____ 8. Keeps fellow staff members informed

Comments:

II. Communication
- _____ 1. Communicates effectively with fellow staff members
- _____ 2. Exhibits good oral communication skills
- _____ 3. Exhibits good written communication skills

Comments:

III. Personal Characteristics

_____ 1. Dresses appropriately for activities concerned

_____ 2. Demonstrates good problem solving techniques

Comments:

IV. Additional Comments by Evaluator:

V. Additional Comments by Teacher:

Observation dates: First _____ Second _____

---

| | | |
|---|---|---|
| Rating Scale: | 5. | Superior (well above expected level) |
| | 4. | Excellent (above expected level) |
| | 3. | Satisfactory (meets the expected level) |
| | 2. | Below expected level (some improvement needed - improvement plan may be required, and suggestions will be included) |
| | 1. | Unsatisfactory (improvement plan required) |
| | NA | Not applicable |
| | Unmarked | Not Observed |

---

The teacher's signature indicates that all phases of the evaluation have been conducted with the full knowledge of the teacher and does not necessarily indicate agreement with the contents of the completed form.

Teacher's Signature _____ Date _____

Evaluator's Signature _____ Date _____

**Appendix D**

Evaluator/Observer

ASHLAND COUNTY-WEST HOLMES CAREER CENTER

Professional Performance Evaluation

Name _____ Date _____

Assignment _____

_____ 1. Exhibits professional growth
_____ 2. Demonstrates intra-staff cooperation
_____ 3. Completes out-of-class assignments and duties
_____ 4. Shows interest in school related activities
_____ 5. Complies with rules and regulations
_____ 6. Fulfills assignments in a timely manner
_____ 7. Communicates effectively with parents
_____ 8. Uses advisory committee effectively
_____ 9. Dresses appropriately for activities concerned
_____ 10. Possesses effective written and oral communication skills
_____ 11. Shows evidence of tact and good judgment
_____ 12. Accepts constructive suggestions

Comments by Evaluator:

Comments by Teacher:

---

| | | |
|---|---|---|
| Rating Scale: | 5. | Superior (well above expected level) |
| | 4. | Excellent (above expected level) |
| | 3. | Satisfactory (meets the expected level) |
| | 2. | Below expected level (some improvement needed - improvement plan may be required, and suggestions will be included) |
| | 1. | Unsatisfactory (improvement plan required) |
| | NA | Not applicable |
| | Unmarked | Not Observed |

---

The teacher's signature indicates that all phases of the evaluation have been conducted with the full knowledge of the teacher and does not necessarily indicate agreement with the contents of the completed form.

Teacher's Signature _____ Date _____

Evaluator's Signature _____ Date _____

# Appendix E

**Ohio Teacher Evaluation System** | **Self-Assessment**

## Self-Assessment Summary Tool

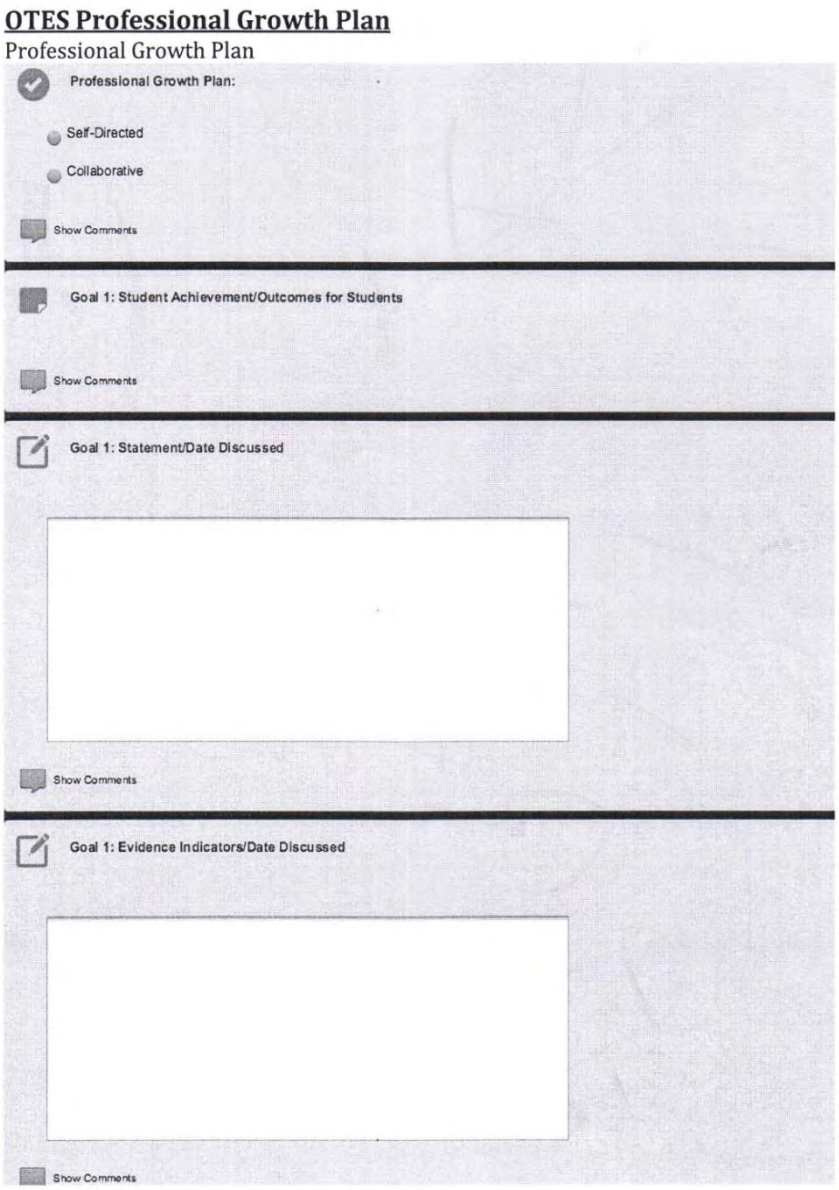
Name _____

**Directions**: Teachers should record evidence to indicate strengths and areas for growth for each standard. Then, look across all of the standards holistically and identify two priorities for the upcoming year. Note these two priorities with check marks in the far-right column.

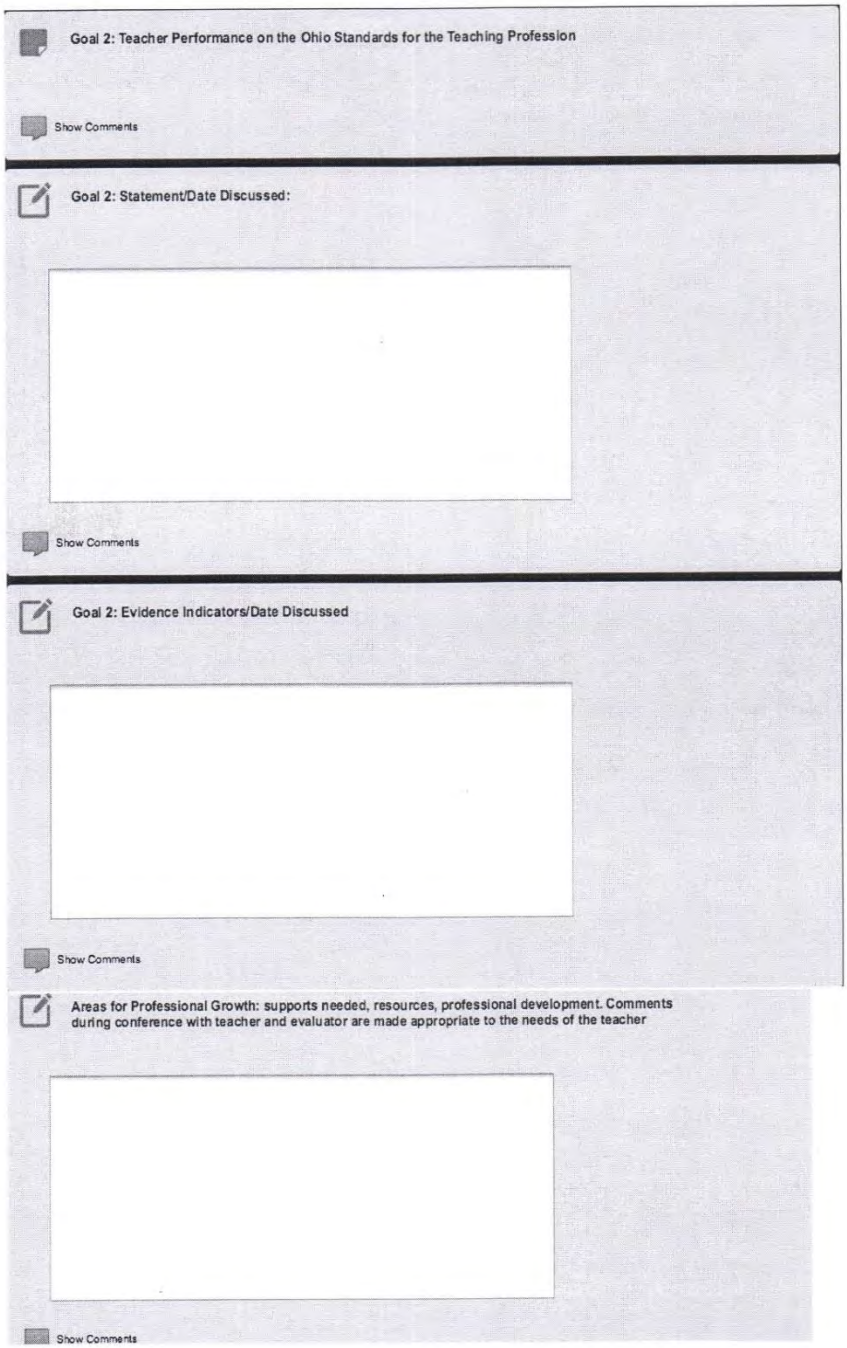
Date _____

| | Standard | Strengths | Areas for Growth | Priorities (Check 2) |
|---|---|---|---|---|
| Standard 1: Students | • Knowledge of how students learn and of student development<br>• Understanding of what students know and are able to do<br>• High expectations for all students<br>• Respect for all students<br>• Identification, instruction and intervention for special populations | | | |
| Standard 2: Content | • Knowledge of content<br>• Use of content- specific instructional strategies to teach concepts and skills<br>• Knowledge of school and district curriculum priorities and Ohio academic content standards<br>• Relationship of knowledge within the discipline to other content areas<br>• Connection of content to life experiences and career opportunities | | | |
| Standard 3: Assessment | • Knowledge of assessment types<br>• Use of varied diagnostic, formative and summative assessments<br>• Analysis of data to monitor student progress and to plan, differentiate, and modify instruction<br>• Communication of results<br>• Inclusion of student self-assessment and goal-setting | | | |
| Standard 4: Instruction | • Alignment to school and district priorities and Ohio academic content standards<br>• Use of student information to plan and deliver instruction<br>• Communication of clear learning goals<br>• Application of knowledge of how students learn to instructional design and delivery<br>• Differentiation of instruction to support learning needs of all students<br>• Use of activities to promote independence and problem-solving<br>• Use of varied resources to support learner needs | | | |
| Standard 5: Learning Environment | • Fair and equitable treatment of all students<br>• Creation of a safe learning environment<br>• Use of strategies to motivate students to work productively and assume responsibility for learning<br>• Creation of learning situations for independent and collaborative work<br>• Maintenance an environment that is conducive to learning for all students | | | |
| Standard 6: Collaboration & Communication | • Clear and effective communication<br>• Shared responsibility with parents/caregivers to support student learning<br>• Collaboration with other teachers, administrators, school and district staff<br>• Collaboration with local community agencies | | | |
| Standard 7: Professional Responsibility and Growth | • Understanding of and adherence to professional ethics, policies and legal codes<br>• Engagement in continuous, purposeful professional development<br>• Desire to serve as an agent of change, seeking positive impact on teaching quality and student achievement | | | |

**Appendix F**


OTES Professional Growth Plan
Professional Growth Plan
Professional Growth Plan:
Self-Directed
Collaborative
Show Comments
Goal 1: Student Achievement/Outcomes for Students
Show Comments
Goal 1: Statement/Date Discussed
Show Comments
Goal 1: Evidence Indicators/Date Discussed
Show Comments

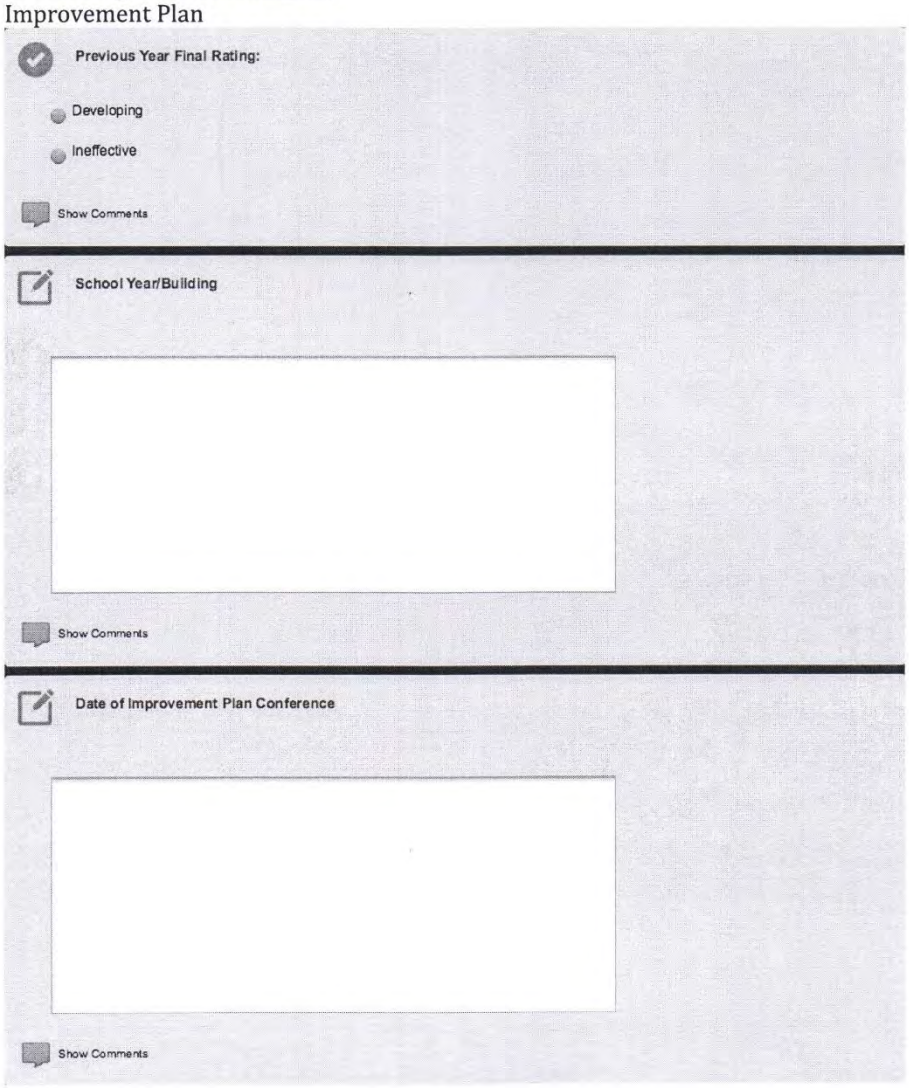
**Appendix F**
**(Continued)**

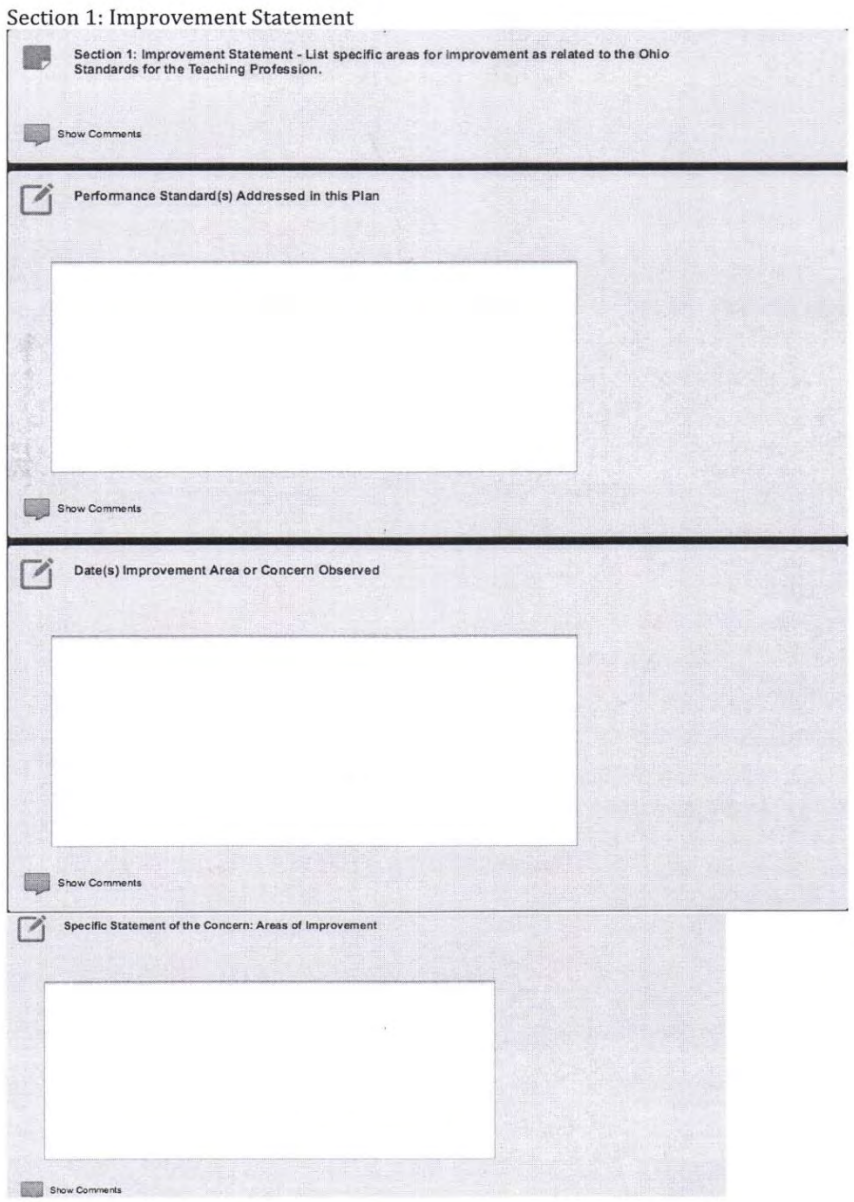


**Appendix G**

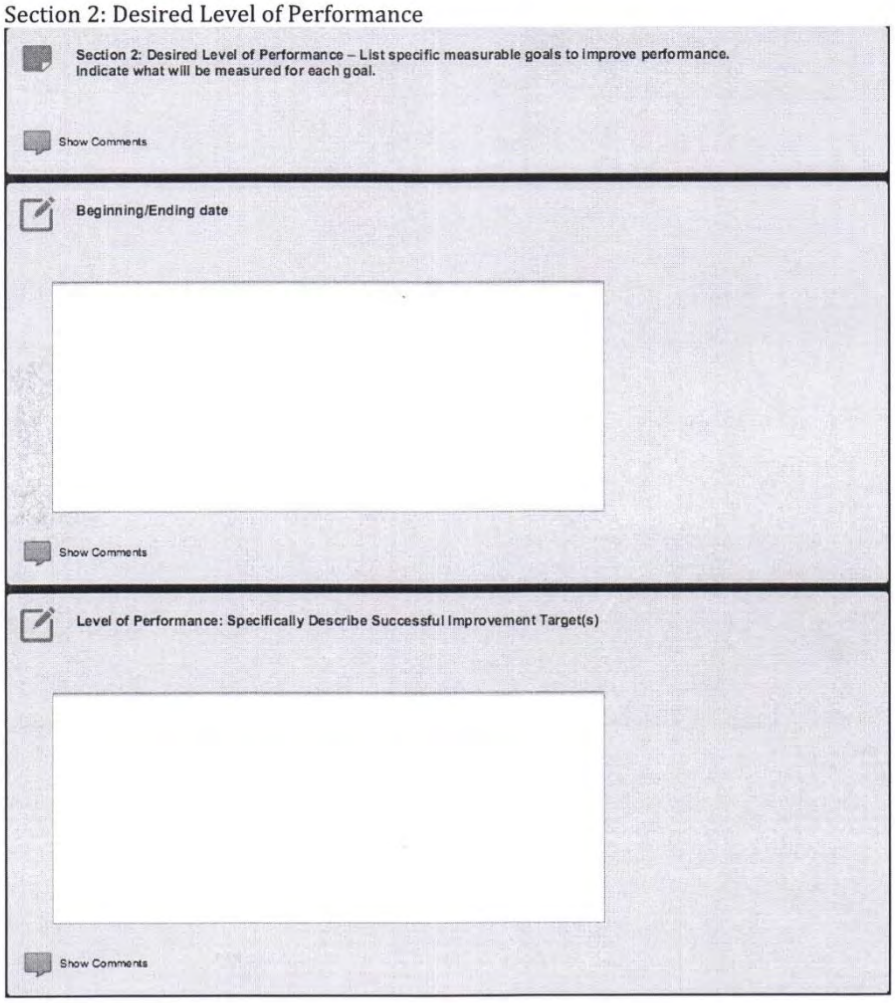
**OTES Improvement Plan**

Improvement Plan

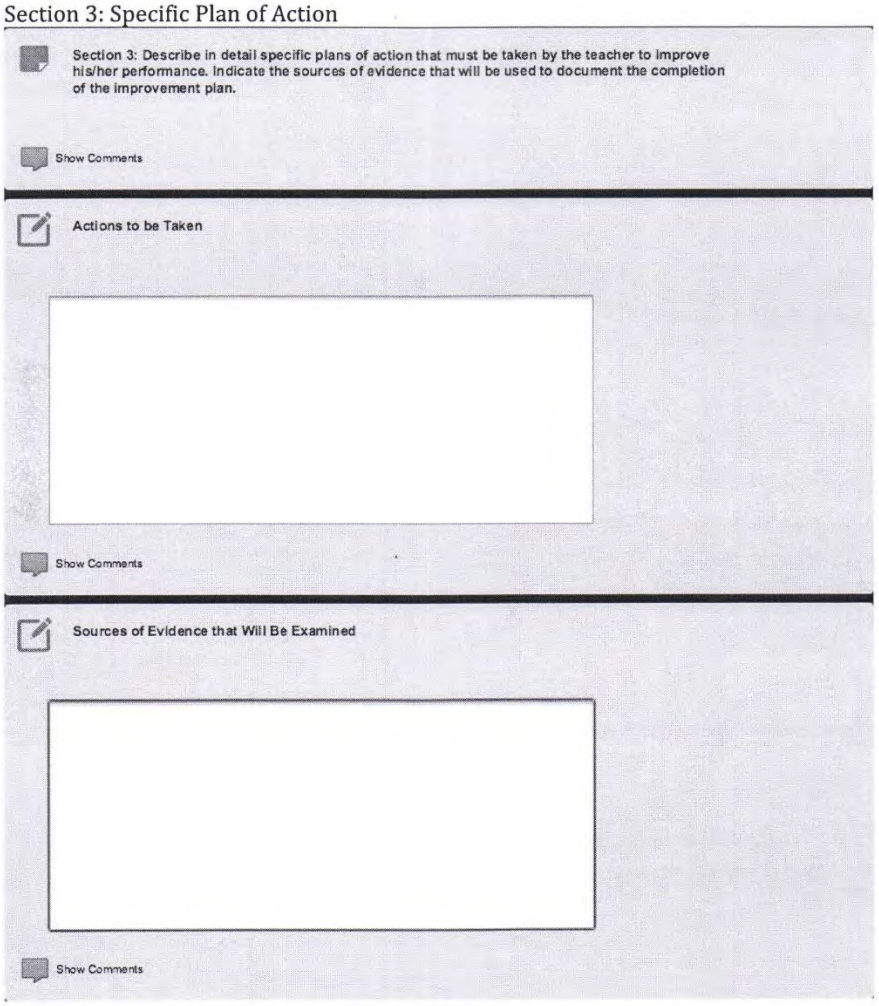



Section 1: Improvement Statement
Section 1: Improvement Statement - List specific areas for improvement as related to the Ohio Standards for the Teaching Profession.
Show Comments
Performance Standard(s) Addressed in this Plan
Show Comments
Date(s) Improvement Area or Concern Observed
Show Comments
Specific Statement of the Concern: Areas of Improvement
Show Comments

Section 2: Desired Level of Performance



Section 3: Specific Plan of Action



Section 4: Assistance and Professional Development

Section 4: Describe in detail specific supports that will be provided as well as opportunities for professional development.

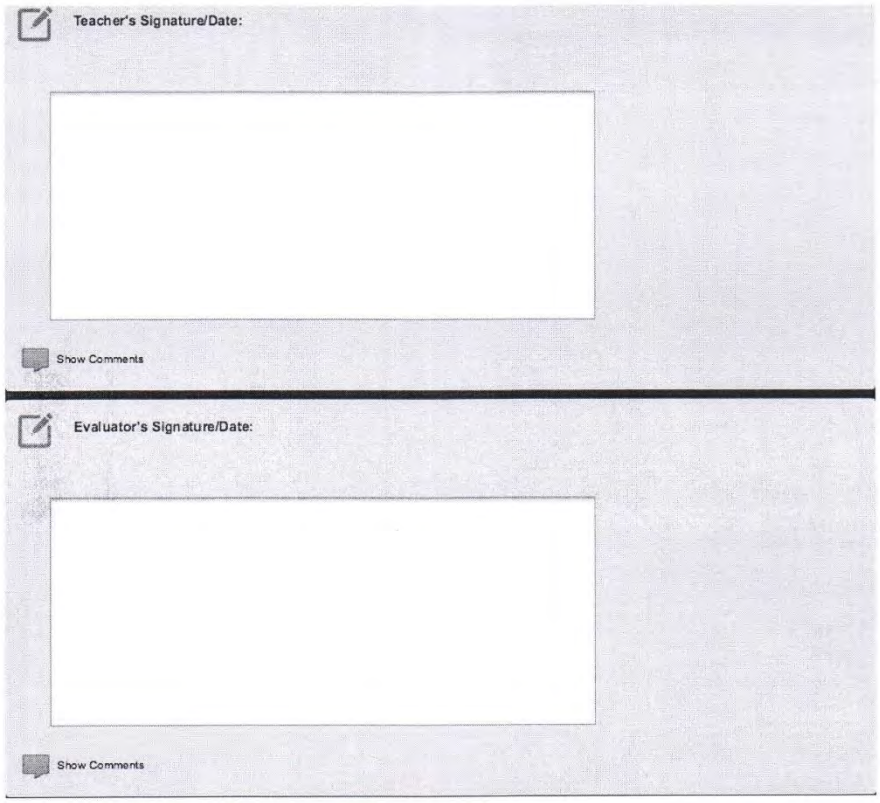
Show Comments

Date for this Improvement Plan to Be Evaluated:

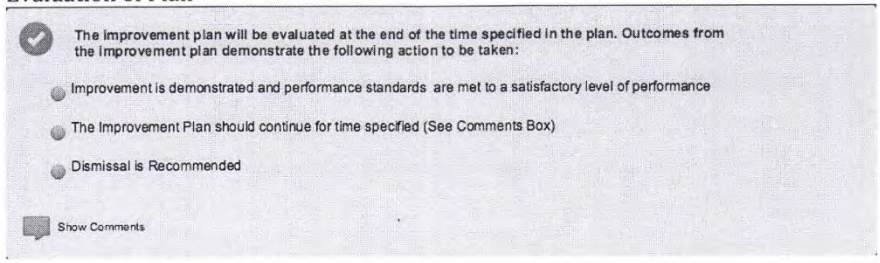
Show Comments

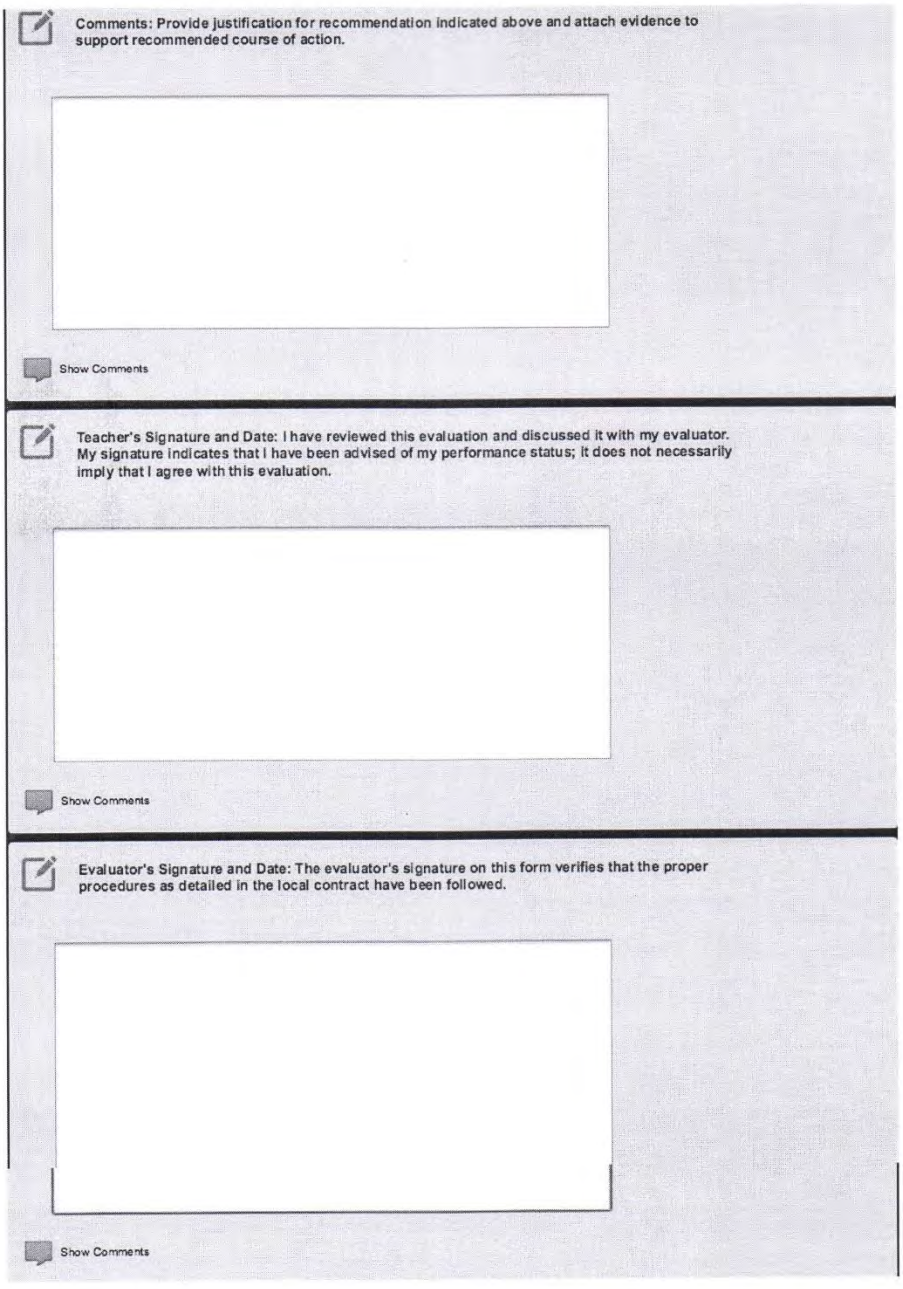
The evaluator's signature on this form verifies that the proper procedures as detailed in the local contract have been followed.

Show Comments



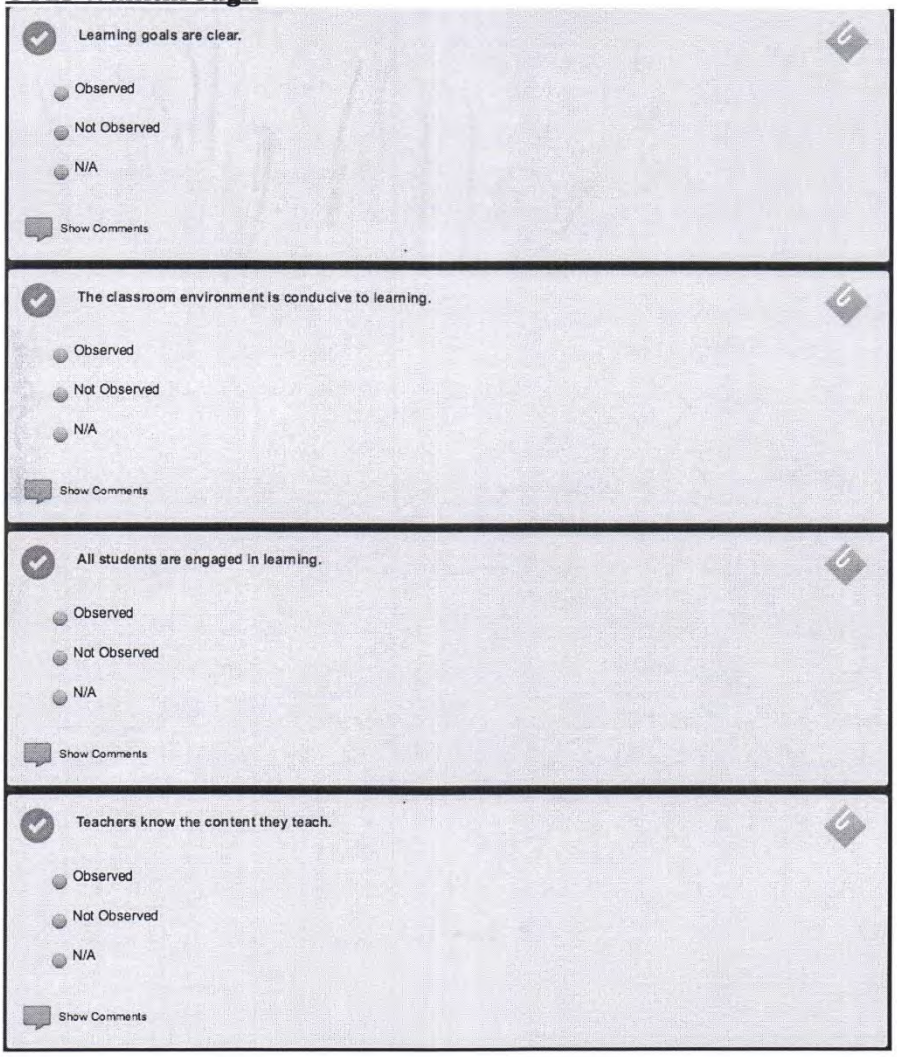

Evaluation of Plan

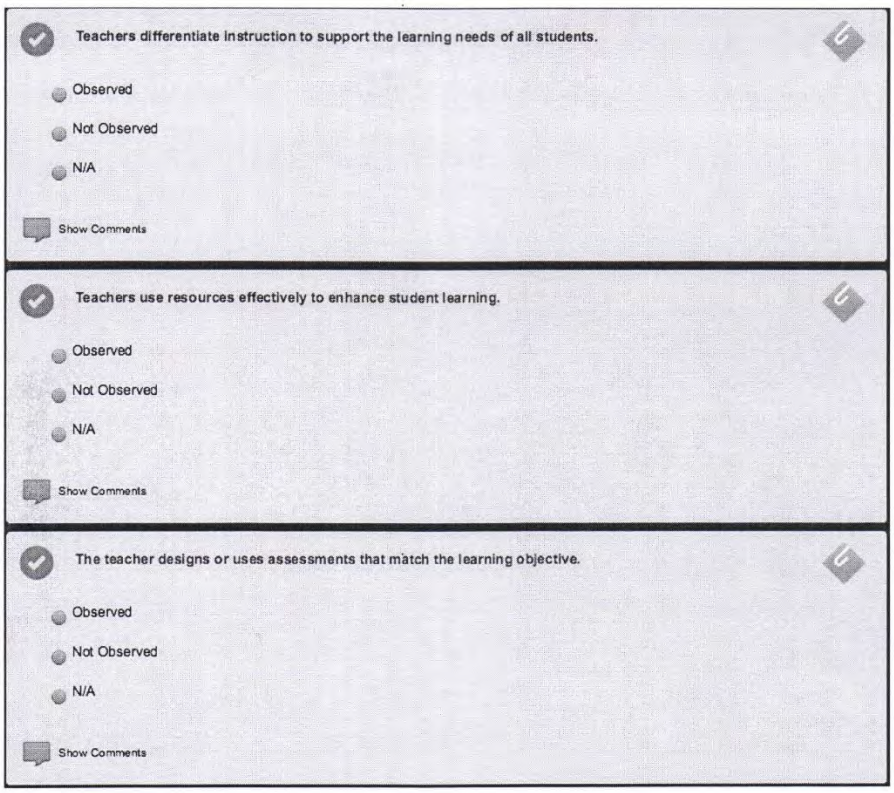



Comments: Provide justification for recommendation indicated above and attach evidence to support recommended course of action.
Show Comments
Teacher's Signature and Date: I have reviewed this evaluation and discussed it with my evaluator. My signature indicates that I have been advised of my performance status; it does not necessarily imply that I agree with this evaluation.
Show Comments
Evaluator's Signature and Date: The evaluator's signature on this form verifies that the proper procedures as detailed in the local contract have been followed.
Show Comments

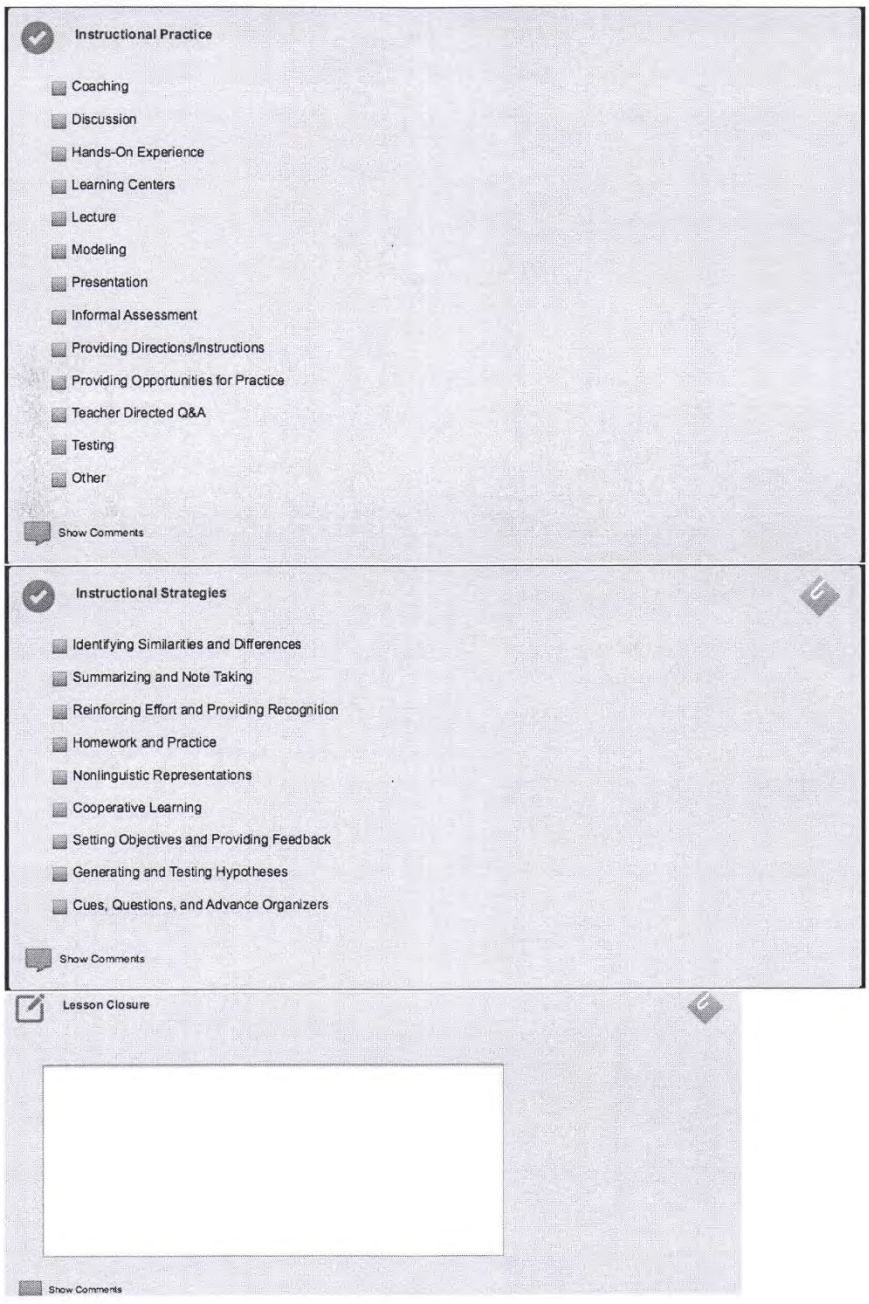
**Appendix H**

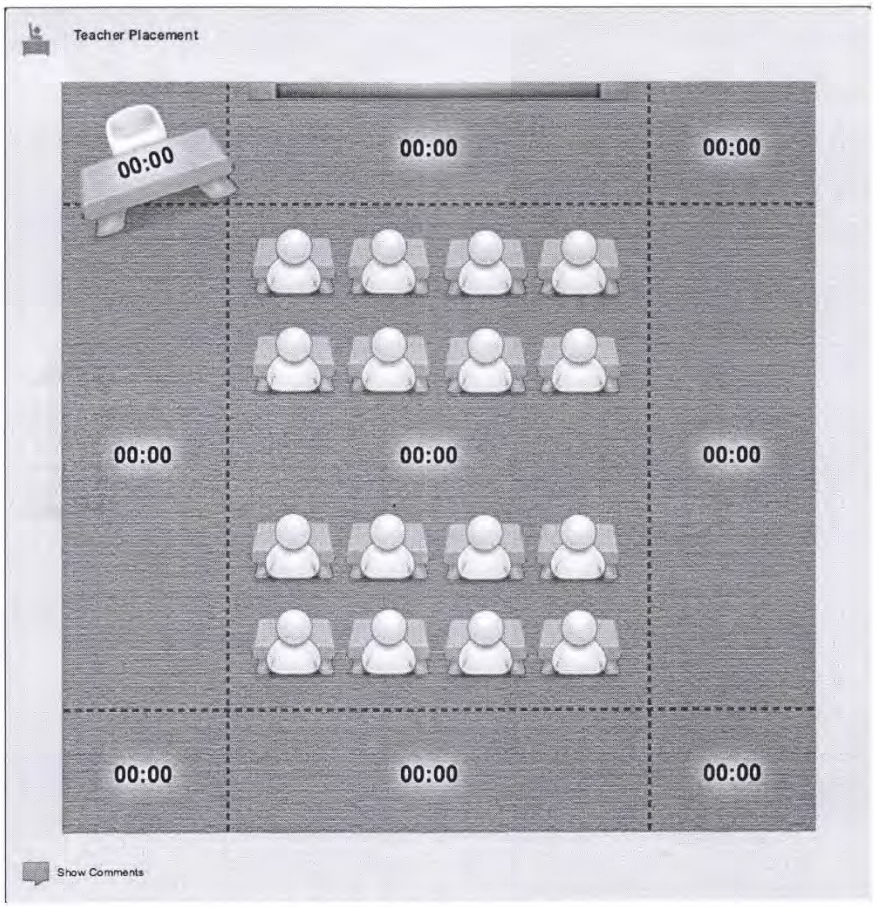
## OTES Walkthrough




Teachers differentiate instruction to support the learning needs of all students.
Observed
Not Observed
N/A
Show Comments
Teachers use resources effectively to enhance student learning.
Observed
Not Observed
N/A
Show Comments
The teacher designs or uses assessments that match the learning objective.
Observed
Not Observed
N/A
Show Comments

**Appendix H**
**(continued)**




Teacher Placement
00:00
00:00
00:00
00:00
00:00
00:00
00:00
00:00
00:00
Show Comments

## Appendix I

## OTES Pre-Conference Questions

**Instructional Planning Focus (Standard 4: Instruction)**

What is the focus for the lesson?

Observed:

What content will students know/understand? What skills will they demonstrate?

Observed:

What standards are addressed in the planned instruction?

Observed:

Why is this learning important?

Observed:

**Assessment Data (Standard 3: Assessment)**

What assessment data was examined to inform this lesson planning?

Observed:

What does pre-assessment data indicate about student learning needs?

Observed:

**Prior Content Knowledge/Sequence/Connections (Standard 1: Students / Standard 2: Content / Standard 4: Instruction)**

What prior knowledge do students need?

Observed:

What are the connections to previous and future learning?

Observed:

How does this lesson connect to students' real-life experiences and/or possible careers?

Observed:

How does it connect to other disciplines?

Observed:

**Knowledge of Students (Standard 1: Students)**

What should the evaluator know about the student population? (See Data Measures Inventory for the Classroom)

Observed:

How is this a developmentally appropriate learning activity?

Observed:

**Instruction and Assessment Lesson Delivery (Standard 2: Content / Standard 4: Instruction)**

How will the goals for learning be communicated to students?

Observed:

What instructional strategies and methods will be used to engage students and promote independent learning and problem solving?

Observed:

What strategies will be used to make sure all students achieve lesson goals?

Observed:

How will content-specific concepts, assumptions, and skills be taught?

Observed:

**Differentiation (Standard 1: Students / Standard 4: Instruction)**

How will the instructional strategies address all students' learning needs?

Observed:

How will the lesson engage and challenge students of all levels?

Observed:

How will developmental gaps be addressed?

Observed:

**Resources (Standard 2: Content / Standard 4: Instruction)**

What resources/materials will be used in instruction?

Observed:

How will technology be integrated into lesson delivery?

Observed:

**Classroom Environment (Standard 1: Students / Standard 5: Learning Environment)**

How will the environment support all students?

Observed:

How will different grouping strategies be used?

Observed:

How will safety in the classroom be ensured?

Observed:

How will respect for all be modeled and taught?

Observed:

**Appendix I**
**(continued)**

**Assessment of Student Learning (Standard 3: Assessment)**

How will you check for understanding during the lesson?

Observed:

What specific products or demonstrations will assess student learning / achievement of goals for instruction?

Observed:

How will you ensure that students understand how they are doing and support students' self-assessment?

Observed:

How will you use assessment data to inform your next steps?

Observed:

**Professional Responsibilities Collaboration and Communication (Standard 6)**

How do you cooperate with colleagues?

Observed:

How do you work with others when there is a problem?

Observed:

What is your communication style with students? With families? With colleagues?

Observed:

In what ways do you seek the perspectives of others? Give an example.

Observed:

**Professional Responsibility and Growth (Standard 7)**

How do you apply knowledge gained from other experiences into your teaching?

Observed:

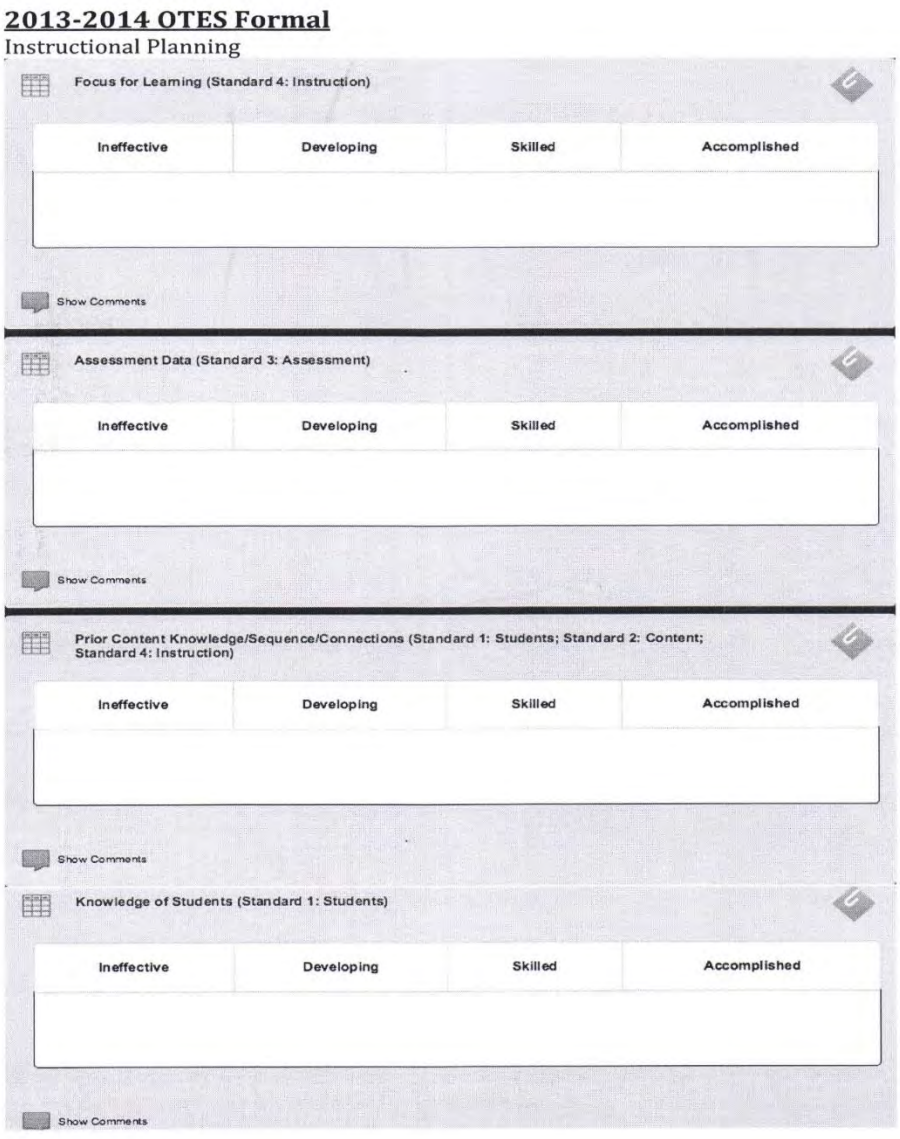
Discuss ways you reflect and analyze your teaching.

Observed:

What are some proactive ways you further your own professional growth?

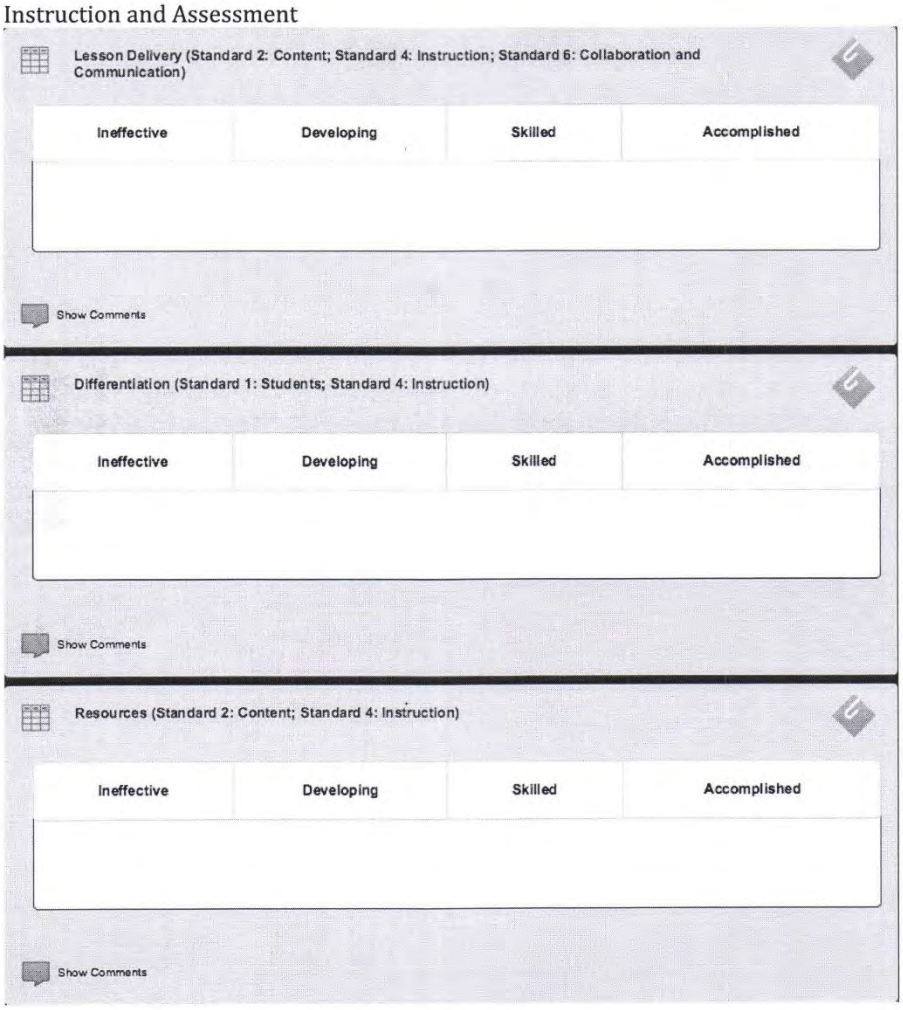
Observed:

**Appendix J**

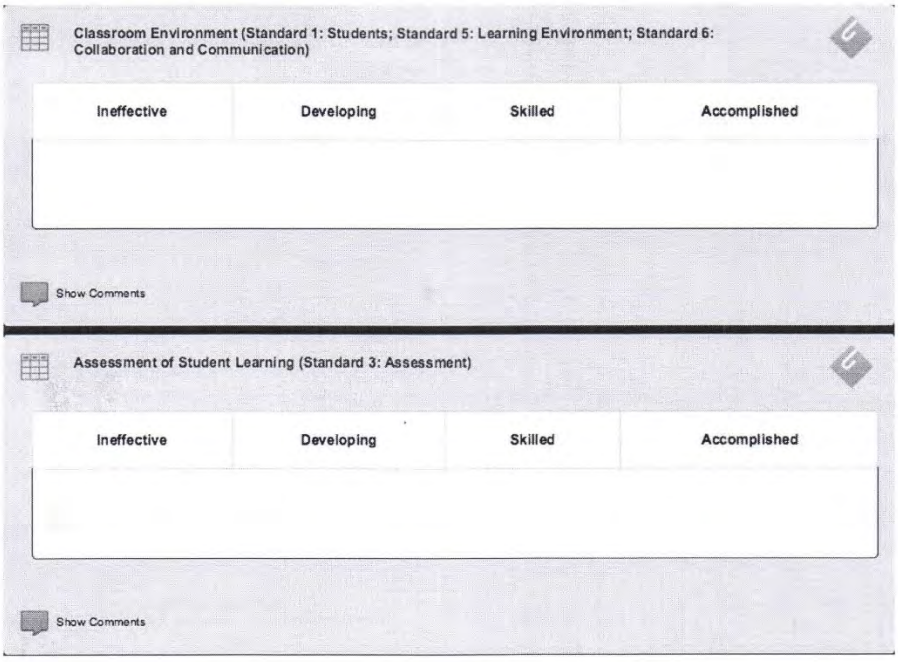

2013-2014 OTES Formal
Instructional Planning
Focus for Learning (Standard 4: Instruction)
Ineffective
Developing
Skilled
Accomplished
Show Comments
Assessment Data (Standard 3: Assessment)
Ineffective
Developing
Skilled
Accomplished
Show Comments
Prior Content Knowledge/Sequence/Connections (Standard 1: Students; Standard 2: Content; Standard 4: Instruction)
Ineffective
Developing
Skilled
Accomplished
Show Comments
Knowledge of Students (Standard 1: Students)
Ineffective
Developing
Skilled
Accomplished
Show Comments

**Appendix J**
**(continued)**

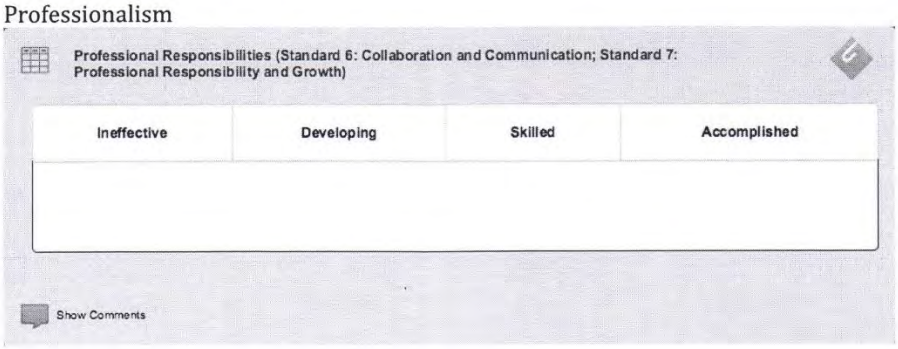
Instruction and Assessment



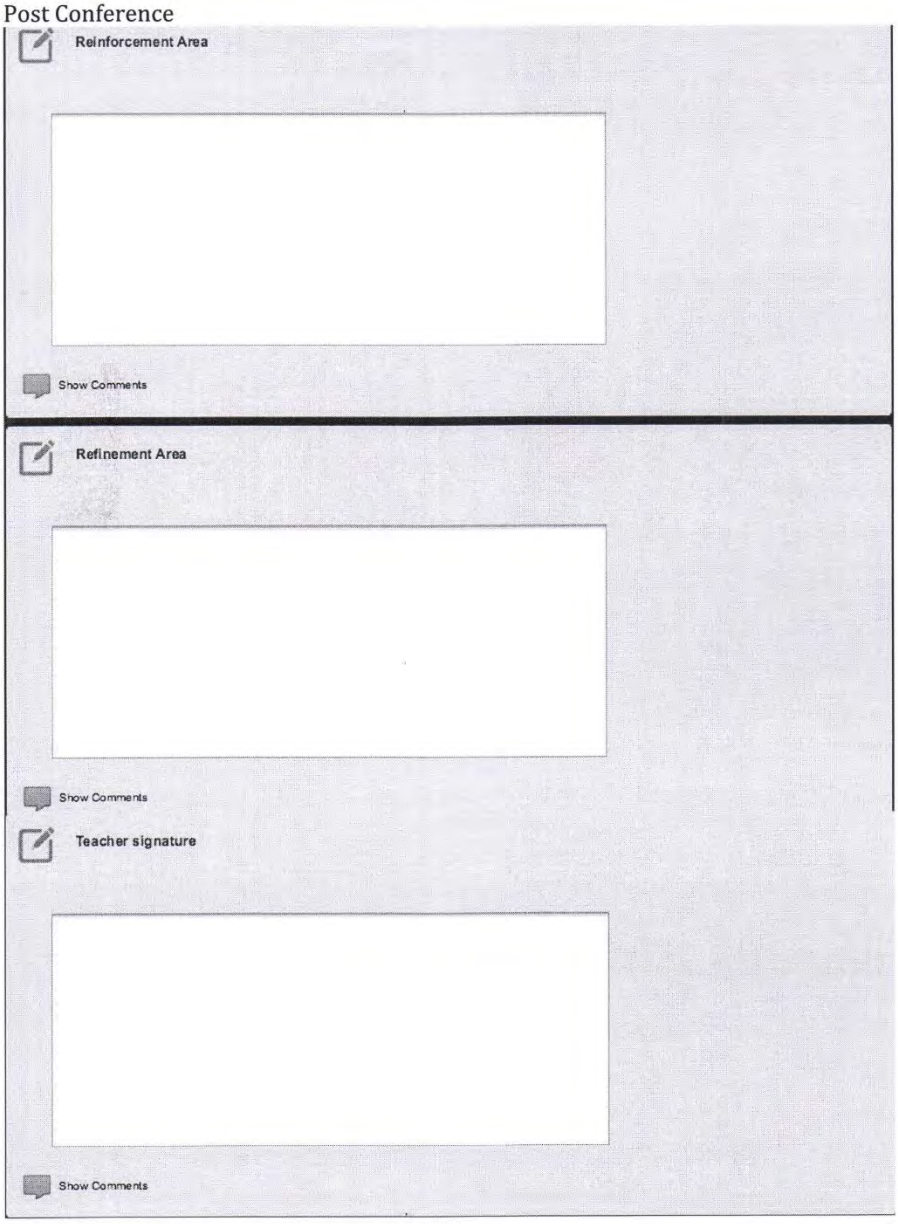
**Appendix J**
**(continued)**

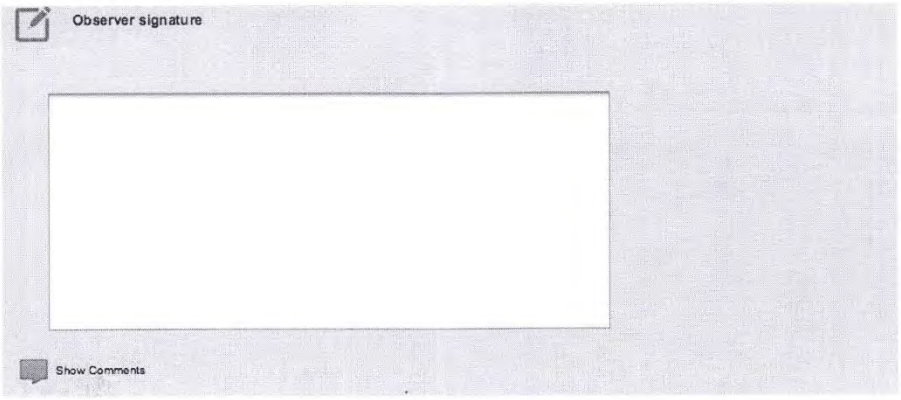



Professionalism



Post Conference




Observer signature
Show Comments

## Appendix K

## OTES Post Conference

**Focus For Learning**

What was the focus for the lesson?

Observed:

Talk about the content that you hoped students would know and understand by the end of the lesson. What skills did they demonstrate to you?

Observed:

What standards were addressed in the planned instruction?

Observed:

Why was this learning important?

Observed:

How was the appropriateness of the goal communicated to students?

Observed:

How did your stated goals fit into the unit, course and school goals?

Observed:

**Assessment Data**

What assessment data was examined to inform the planning for the observed lesson?

Observed:

What did pre-assessment data indicate about student learning needs?

Observed:

What formal or informal techniques did you use to collect evidence of students' knowledge and skills?

Observed:

How did your assessment data help you identify student strengths and areas of improvement?

Observed:

**Prior Content Knowledge/Sequence/Connections**

What prior knowledge did students need and how did you connect that to their future learning?

Observed:

How did this lesson connect to students' real-life experiences and/or possible careers?

Observed:

How did it connect to other disciplines?

Observed:

**Knowledge of Students**

How did this lesson demonstrate your familiarity with the students' background knowledge and experiences?

Observed:

What strategies did you plan for and implement to meet the needs of individual students?

Observed:

Talk about how this lesson was developmentally appropriate for your students.

Observed:

**Lesson Delivvery**

How were the goals for learning communicated to students?

Observed:

What instructional strategies and methods were used to engage students and promote independent learning and problem solving?

Observed:

What strategies were used to make sure all students achieve lesson goals?

Observed:

How were content-specific concepts, assumptions and skills taught?

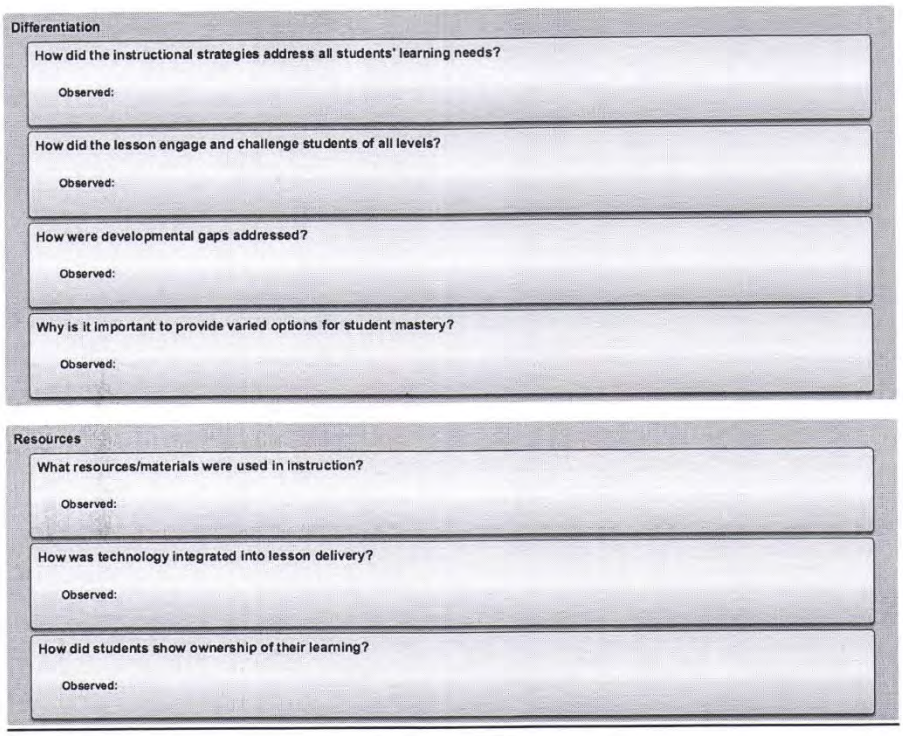
Observed:

What questioning techniques did you use to support student learning?

Observed:

How did you ensure this lesson was student led?

Observed:


Differentiation
How did the instructional strategies address all students' learning needs?
Observed:
How did the lesson engage and challenge students of all levels?
Observed:
How were developmental gaps addressed?
Observed:
Why is it important to provide varied options for student mastery?
Observed:
Resources
What resources/materials were used in instruction?
Observed:
How was technology integrated into lesson delivery?
Observed:
How did students show ownership of their learning?
Observed:

**Classroom Envrionment**

How did the environment support all students?

Observed:

How were different grouping strategies used?

Observed:

How was safety in the classroom ensured?

Observed:

How was respect for all modeled and taught?

Observed:

**Assessment of Student Learning**

How did you check for understanding during the lesson?

Observed:

What specific products or demonstrations assessed student learning/achievement of goals for instruction?

Observed:

How did you ensure that students understand how they are doing and support students' self assessment?

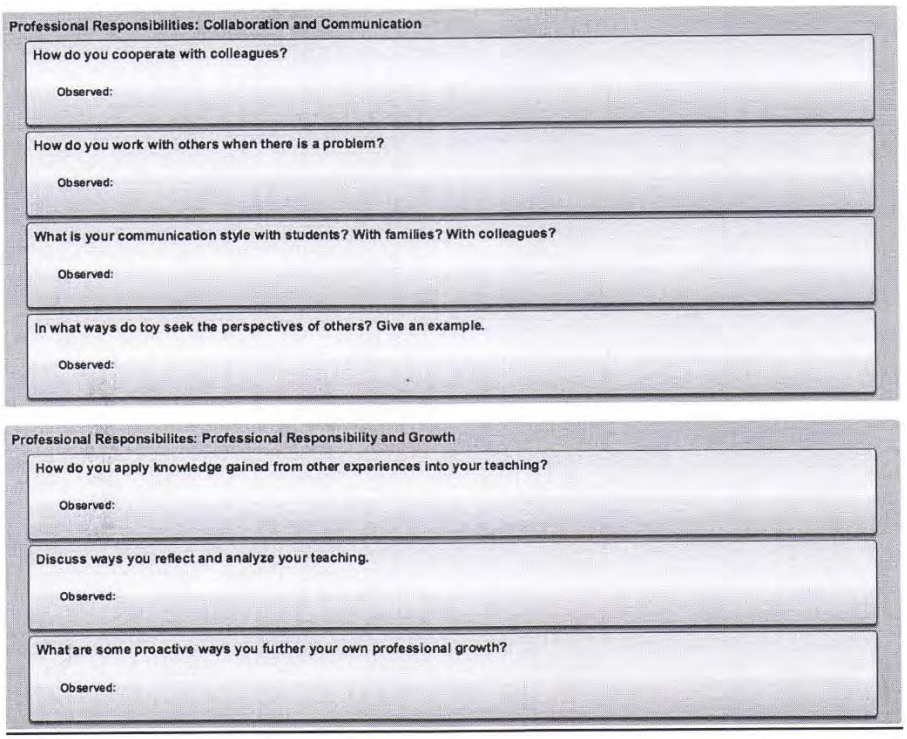
Observed:

How did you use assessment data to inform your next steps?

Observed:

Why is it important to provide specific and timely feedback?

Observed:



**Professional Responsibilities: Collaboration and Communication**

How do you cooperate with colleagues?

Observed:

How do you work with others when there is a problem?

Observed:

What is your communication style with students? With families? With colleagues?

Observed:

In what ways do toy seek the perspectives of others? Give an example.

Observed:

**Professional Responsibilites: Professional Responsibility and Growth**

How do you apply knowledge gained from other experiences into your teaching?

Observed:

Discuss ways you reflect and analyze your teaching.

Observed:

What are some proactive ways you further your own professional growth?

Observed:

**Appendix L**

## OTES Summative

Proficiency on Standards/Teacher Performances

**Cumulative/Holistic Rating for Performance Evaluation/Observation #1:**

- Ineffective
- Developing
- Skilled
- Accomplished

Show Comments

**Cumulative/Holistic Rating for Performance Evaluation/Observation #2:**

- Ineffective
- Developing
- Skilled
- Accomplished

Show Comments

**Summative Rating for both Performance Evaluations:**

- Ineffective
- Developing
- Skilled
- Accomplished

Show Comments

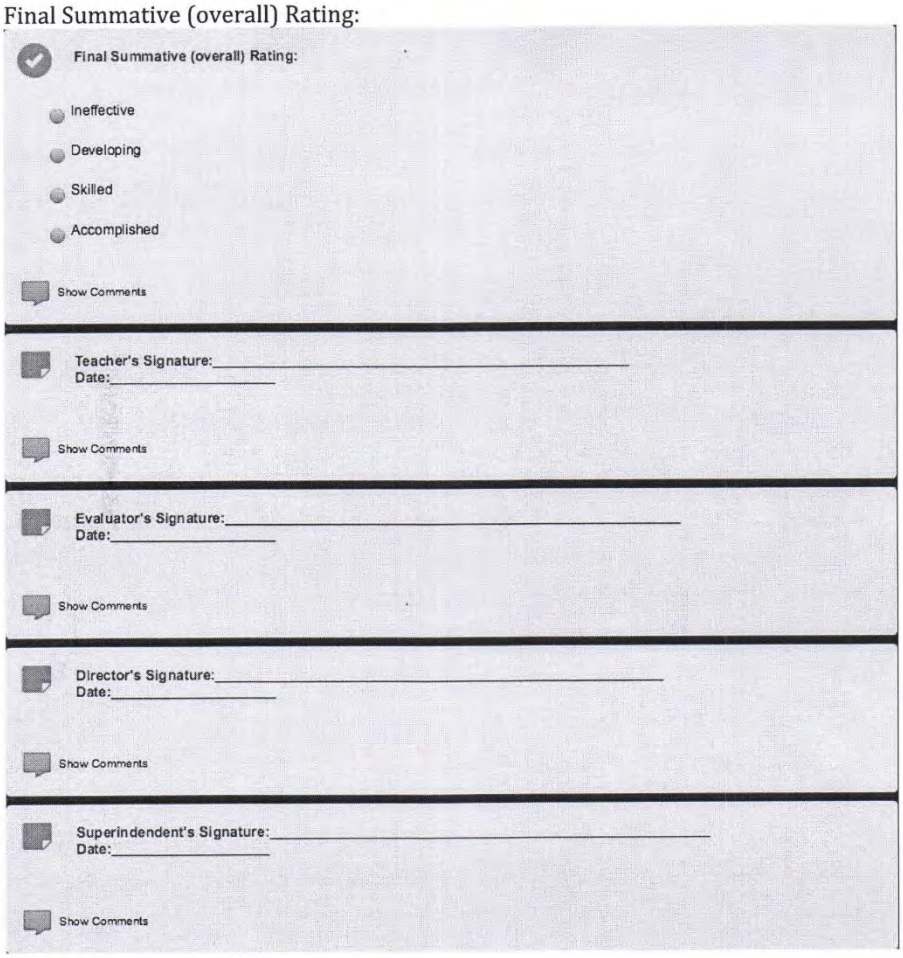
Student Growth Data

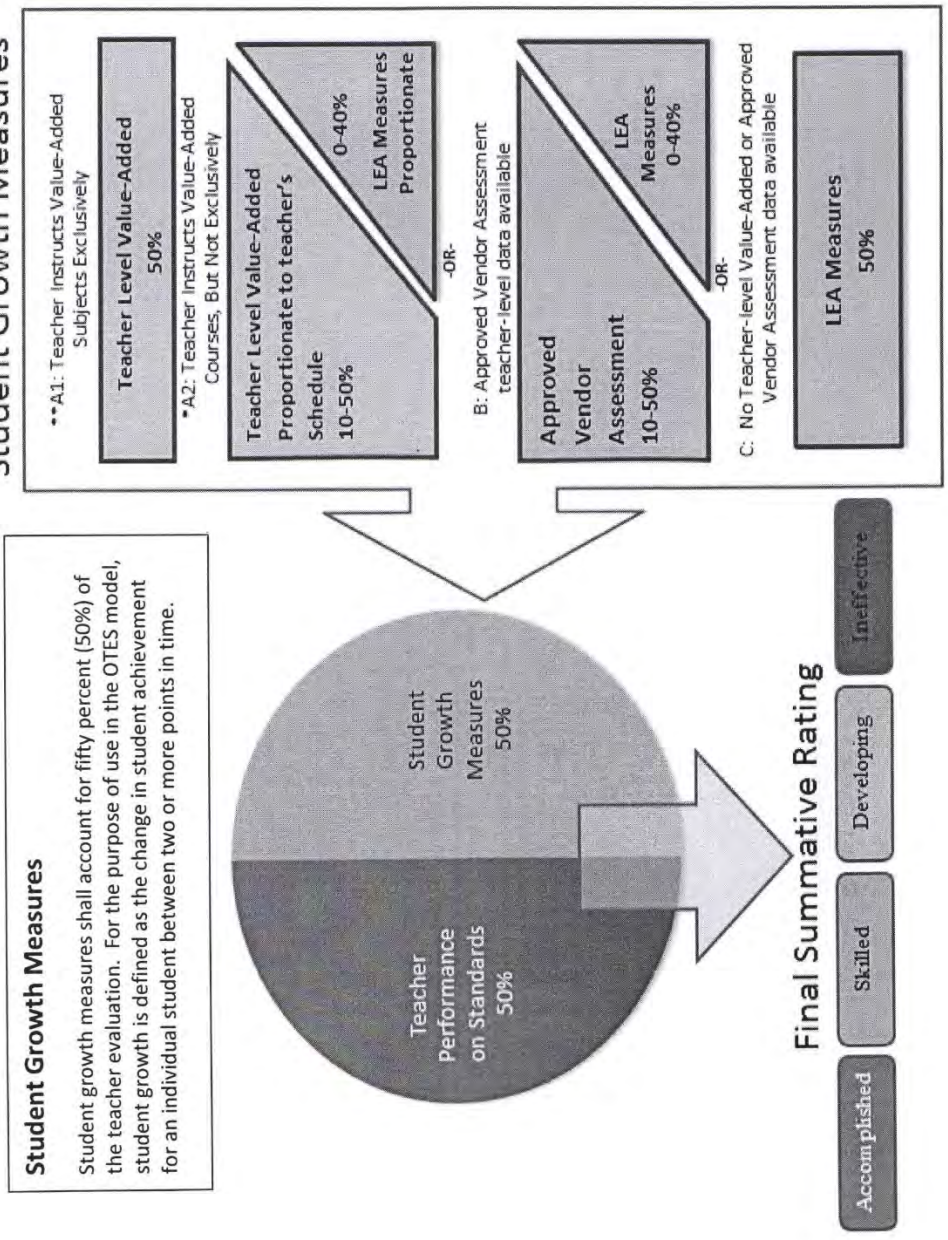
**Student Growth Measure of Effectiveness**

- Below Expected Growth
- Expected Growth
- Above Expected Growth

Show Comments

Final Summative (overall) Rating:




Student Growth Measures
**A1: Teacher Instructs Value-Added Subjects Exclusively
Teacher Level Value-Added 50%
*A2: Teacher Instructs Value-Added Courses, But Not Exclusively
Teacher Level Value-Added Proportionate to teacher's Schedule 10-50%
0-40% LEA Measures Proportionate
-OR-
B: Approved Vendor Assessment teacher-level data available
Approved Vendor Assessment 10-50%
LEA Measures 0-40%
-OR-
C: No Teacher-level Value-Added or Approved Vendor Assessment data available
LEA Measures 50%
Student Growth Measures
Student growth measures shall account for fifty percent (50%) of the teacher evaluation. For the purpose of use in the OTES model, student growth is defined as the change in student achievement for an individual student between two or more points in time.
Teacher Performance on Standards 50%
Student Growth Measures 50%
Final Summative Rating
Accomplished
Skilled
Developing
Ineffective

**Appendix N**

**ASHLAND COUNTY-WEST HOLMES CAREER CENTER**

Continuous Improvement Plan

Name _____ Date _____

Assignment_____

I. Goal(s):

II. Means to Achieve Goal(s):

III. Supervisory Assistance:

IV. How Will Achievement Be Measured?

V. Was (Were) the Goal(s) Achieved?

Planning Conference Date _____ Follow-up Conference Date_____

VI. Additional Comments by Evaluator

VII. Comments by Teacher

---

The teacher's signature indicates that all phases of the evaluation have been conducted with the full knowledge of the teacher, and does not necessarily indicate agreement with the contents of the completed form.

Teacher's Signature _____ Date _____

Observer's Signature _____ Date _____

**Appendix O**

Sick Leave Transfer Program
Donation Form

ASHLAND COUNTY-WEST HOLMES CAREER CENTER

SICK LEAVE TRANSFER PROGRAM
(Sick Leave Pool)

# DONATION FORM

Submit to Treasurer's Office

NAME_____DATE_____

SOCIAL SECURITY NUMBER_____

I hereby donate _____ day(s) of my accumulated sick leave (not to exceed five (5) days per year) to the Sick Leave Transfer Program. I have also read the guidelines of the program and understand the intent of the program. (Article V, Section C)

_____
Signature of Donor

_____
Date

Posted to Sick Leave Bank: Date: _____

By: _____

Sick Leave Balance Reduced: Date: _____

By: _____

**Appendix P**

Sick Leave Transfer Program
Application Form

ASHLAND COUNTY-WEST HOLMES CAREER CENTER

SICK LEAVE TRANSFER PROGRAM
(Sick Leave Pool)

# APPLICATION FORM

Submit to Treasurer's Office

_____ New Application _____ Renewal Application

Reason(s) for making application: _____

_____

_____

_____

Expiration date of accrued and/or advanced sick leave: _____

_____

Name and address of attending physician(s): _____

_____

_____

Expected date of return to work: _____

_____

_____ _____
Print Name of Applicant Signature of Applicant

_____
Date

**Appendix Q**

## TEACHER SALARY INDEX – FY2017-20
## ASHLAND COUNTY-WEST HOLMES JOINT VOCATIONAL SCHOOL DISTRICT

| | CAT 1 BA | CAT 2 135 HRS | CAT 3 150 HRS | CAT 4 175 HRS | CAT 5 MASTERS | CAT 6 MA+10 | CAT 7 MA+20 | CAT 8 MA+30 | CAT 9 MA+40 |
|---|---|---|---|---|---|---|---|---|---|
| STEP 0 | 1.0000 | 1.0420 | 1.0450 | 1.0480 | 1.1000 | 1.1400 | 1.1800 | 1.2200 | 1.2600 |
| STEP 1 | 1.0400 | 1.0840 | 1.0910 | 1.0980 | 1.1500 | 1.1900 | 1.2300 | 1.2700 | 1.3100 |
| STEP 2 | 1.0800 | 1.1260 | 1.1370 | 1.1480 | 1.2000 | 1.2400 | 1.2800 | 1.3200 | 1.3600 |
| STEP 3 | 1.1200 | 1.1680 | 1.1830 | 1.1980 | 1.2500 | 1.2900 | 1.3300 | 1.3700 | 1.4100 |
| STEP 4 | 1.1600 | 1.2100 | 1.2290 | 1.2480 | 1.3000 | 1.3400 | 1.3800 | 1.4200 | 1.4600 |
| STEP 5 | 1.2000 | 1.2520 | 1.2750 | 1.2980 | 1.3500 | 1.3900 | 1.4300 | 1.4700 | 1.5100 |
| STEP 6 | 1.2400 | 1.2940 | 1.3210 | 1.3480 | 1.4000 | 1.4400 | 1.4800 | 1.5200 | 1.5600 |
| STEP 7 | 1.2800 | 1.3360 | 1.3670 | 1.3980 | 1.4500 | 1.4900 | 1.5300 | 1.5700 | 1.6100 |
| STEP 8 | 1.3200 | 1.3780 | 1.4130 | 1.4480 | 1.5000 | 1.5400 | 1.5800 | 1.6200 | 1.6600 |
| STEP 9 | 1.3600 | 1.4200 | 1.4590 | 1.4980 | 1.5500 | 1.5900 | 1.6300 | 1.6700 | 1.7100 |
| STEP 10 | 1.4000 | 1.4620 | 1.5050 | 1.5480 | 1.6000 | 1.6400 | 1.6800 | 1.7200 | 1.7600 |
| STEP 11 | 1.4400 | 1.5040 | 1.5510 | 1.5980 | 1.6500 | 1.6900 | 1.7300 | 1.7700 | 1.8100 |
| STEP 12 | 1.4800 | 1.5460 | 1.5970 | 1.6480 | 1.7000 | 1.7400 | 1.7800 | 1.8200 | 1.8600 |
| STEP 13 | 1.5200 | 1.5880 | 1.6430 | 1.6980 | 1.7500 | 1.7900 | 1.8300 | 1.8700 | 1.9100 |
| STEP 14 | 1.5600 | 1.6300 | 1.6890 | 1.7480 | 1.8000 | 1.8400 | 1.8800 | 1.9200 | 1.9600 |
| STEP 18 | 1.5900 | 1.6600 | 1.7200 | 1.7800 | 1.8500 | 1.8900 | 1.9300 | 1.9700 | 2.0100 |
| STEP 22 | 1.6200 | 1.6900 | 1.7500 | 1.8100 | 1.9000 | 1.9400 | 1.9800 | 2.0200 | 2.0600 |
| STEP 26 | 1.6500 | 1.7200 | 1.7800 | 1.8400 | 1.9500 | 1.9900 | 2.0300 | 2.0700 | 2.1100 |

## Appendix R

TEACHER SALARY SCHEDULE 2017-18

| | CAT 1 | CAT 2 | CAT 3 | CAT 4 | CAT 5 | CAT 6 | CAT 7 | CAT 8 | CAT 9 |
|---|---|---|---|---|---|---|---|---|---|
| | BA | 135 HRS | 150 HRS | 175 HRS | MASTERS | MA+10 | MA+20 | MA+30 | MA+40 |
| STEP 0 | 34,930 | 36,397 | 36,502 | 36,607 | 38,423 | 39,820 | 41,218 | 42,615 | 44,012 |
| STEP 1 | 36,327 | 37,864 | 38,109 | 38,353 | 40,170 | 41,567 | 42,964 | 44,361 | 45,759 |
| STEP 2 | 37,725 | 39,331 | 39,716 | 40,100 | 41,916 | 43,313 | 44,711 | 46,108 | 47,505 |
| STEP 3 | 39,122 | 40,799 | 41,322 | 41,846 | 43,663 | 45,060 | 46,457 | 47,854 | 49,252 |
| STEP 4 | 40,519 | 42,266 | 42,929 | 43,593 | 45,409 | 46,807 | 48,204 | 49,601 | 50,998 |
| STEP 5 | 41,916 | 43,733 | 44,536 | 45,339 | 47,156 | 48,553 | 49,950 | 51,347 | 52,745 |
| STEP 6 | 43,313 | 45,200 | 46,143 | 47,086 | 48,902 | 50,300 | 51,697 | 53,094 | 54,491 |
| STEP 7 | 44,711 | 46,667 | 47,750 | 48,832 | 50,649 | 52,046 | 53,443 | 54,840 | 56,238 |
| STEP 8 | 46,108 | 48,134 | 49,356 | 50,579 | 52,395 | 53,793 | 55,190 | 56,587 | 57,984 |
| STEP 9 | 47,505 | 49,601 | 50,963 | 52,325 | 54,142 | 55,539 | 56,936 | 58,333 | 59,731 |
| STEP 10 | 48,902 | 51,068 | 52,570 | 54,072 | 55,888 | 57,286 | 58,683 | 60,080 | 61,477 |
| STEP 11 | 50,300 | 52,535 | 54,177 | 55,819 | 57,635 | 59,032 | 60,429 | 61,827 | 63,224 |
| STEP 12 | 51,697 | 54,002 | 55,784 | 57,565 | 59,381 | 60,779 | 62,176 | 63,573 | 64,970 |
| STEP 13 | 53,094 | 55,469 | 57,390 | 59,312 | 61,128 | 62,525 | 63,922 | 65,320 | 66,717 |
| STEP 14 | 54,491 | 56,936 | 58,997 | 61,058 | 62,874 | 64,272 | 65,669 | 67,066 | 68,463 |
| STEP 18 | 55,539 | 57,984 | 60,080 | 62,176 | 64,621 | 66,018 | 67,415 | 68,813 | 70,210 |
| STEP 22 | 56,587 | 59,032 | 61,128 | 63,224 | 66,367 | 67,765 | 69,162 | 70,559 | 71,956 |
| STEP 26 | 57,635 | 60,080 | 62,176 | 64,272 | 68,114 | 69,511 | 70,908 | 72,306 | 73,703 |

## Appendix S

TEACHER SALARY SCHEDULE 2018-19

| | CAT 1 | CAT 2 | CAT 3 | CAT 4 | CAT 5 | CAT 6 | CAT 7 | CAT 8 | CAT 9 |
|---|---|---|---|---|---|---|---|---|---|
| | BA | 135 HRS | 150 HRS | 175 HRS | MASTERS | MA+10 | MA+20 | MA+30 | MA+40 |
| STEP 0 | 35,629 | 37,125 | 37,232 | 37,339 | 39,192 | 40,617 | 42,042 | 43,467 | 44,892 |
| STEP 1 | 37,054 | 38,622 | 38,871 | 39,120 | 40,973 | 42,398 | 43,823 | 45,249 | 46,674 |
| STEP 2 | 38,479 | 40,118 | 40,510 | 40,902 | 42,755 | 44,180 | 45,605 | 47,030 | 48,455 |
| STEP 3 | 39,904 | 41,614 | 42,149 | 42,683 | 44,536 | 45,961 | 47,386 | 48,812 | 50,237 |
| STEP 4 | 41,329 | 43,111 | 43,788 | 44,465 | 46,317 | 47,743 | 49,168 | 50,593 | 52,018 |
| STEP 5 | 42,755 | 44,607 | 45,427 | 46,246 | 48,099 | 49,524 | 50,949 | 52,374 | 53,800 |
| STEP 6 | 44,180 | 46,104 | 47,066 | 48,028 | 49,880 | 51,306 | 52,731 | 54,156 | 55,581 |
| STEP 7 | 45,605 | 47,600 | 48,705 | 49,809 | 51,662 | 53,087 | 54,512 | 55,937 | 57,362 |
| STEP 8 | 47,030 | 49,097 | 50,344 | 51,591 | 53,443 | 54,868 | 56,294 | 57,719 | 59,144 |
| STEP 9 | 48,455 | 50,593 | 51,982 | 53,372 | 55,225 | 56,650 | 58,075 | 59,500 | 60,925 |
| STEP 10 | 49,880 | 52,089 | 53,621 | 55,153 | 57,006 | 58,431 | 59,856 | 61,282 | 62,707 |
| STEP 11 | 51,306 | 53,586 | 55,260 | 56,935 | 58,788 | 60,213 | 61,638 | 63,063 | 64,488 |
| STEP 12 | 52,731 | 55,082 | 56,899 | 58,716 | 60,569 | 61,994 | 63,419 | 64,844 | 66,270 |
| STEP 13 | 54,156 | 56,579 | 58,538 | 60,498 | 62,350 | 63,776 | 65,201 | 66,626 | 68,051 |
| STEP 14 | 55,581 | 58,075 | 60,177 | 62,279 | 64,132 | 65,557 | 66,982 | 68,407 | 69,833 |
| STEP 18 | 56,650 | 59,144 | 61,282 | 63,419 | 65,913 | 67,339 | 68,764 | 70,189 | 71,614 |
| STEP 22 | 57,719 | 60,213 | 62,350 | 64,488 | 67,695 | 69,120 | 70,545 | 71,970 | 73,395 |
| STEP 26 | 58,788 | 61,282 | 63,419 | 65,557 | 69,476 | 70,901 | 72,327 | 73,752 | 75,177 |

## Appendix T

TEACHER SALARY SCHEDULE 2019-20

| | CAT 1 | CAT 2 | CAT 3 | CAT 4 | CAT 5 | CAT 6 | CAT 7 | CAT 8 | CAT 9 |
|---|---|---|---|---|---|---|---|---|---|
| | BA | 135 HRS | 150 HRS | 175 HRS | MASTERS | MA+10 | MA+20 | MA+30 | MA+40 |
| STEP 0 | 36,074 | 37,589 | 37,698 | 37,806 | 39,682 | 41,125 | 42,568 | 44,011 | 45,453 |
| STEP 1 | 37,517 | 39,104 | 39,357 | 39,609 | 41,485 | 42,928 | 44,371 | 45,814 | 47,257 |
| STEP 2 | 38,960 | 40,620 | 41,016 | 41,413 | 43,289 | 44,732 | 46,175 | 47,618 | 49,061 |
| STEP 3 | 40,403 | 42,135 | 42,676 | 43,217 | 45,093 | 46,536 | 47,979 | 49,422 | 50,865 |
| STEP 4 | 41,846 | 43,650 | 44,335 | 45,021 | 46,896 | 48,339 | 49,782 | 51,225 | 52,668 |
| STEP 5 | 43,289 | 45,165 | 45,995 | 46,824 | 48,700 | 50,143 | 51,586 | 53,029 | 54,472 |
| STEP 6 | 44,732 | 46,680 | 47,654 | 48,628 | 50,504 | 51,947 | 53,390 | 54,833 | 56,276 |
| STEP 7 | 46,175 | 48,195 | 49,313 | 50,432 | 52,308 | 53,751 | 55,194 | 56,636 | 58,079 |
| STEP 8 | 47,618 | 49,710 | 50,973 | 52,235 | 54,111 | 55,554 | 56,997 | 58,440 | 59,883 |
| STEP 9 | 49,061 | 51,225 | 52,632 | 54,039 | 55,915 | 57,358 | 58,801 | 60,244 | 61,687 |
| STEP 10 | 50,504 | 52,740 | 54,292 | 55,843 | 57,719 | 59,162 | 60,605 | 62,048 | 63,491 |
| STEP 11 | 51,947 | 54,256 | 55,951 | 57,647 | 59,522 | 60,965 | 62,408 | 63,851 | 65,294 |
| STEP 12 | 53,390 | 55,771 | 57,611 | 59,450 | 61,326 | 62,769 | 64,212 | 65,655 | 67,098 |
| STEP 13 | 54,833 | 57,286 | 59,270 | 61,254 | 63,130 | 64,573 | 66,016 | 67,459 | 68,902 |
| STEP 14 | 56,276 | 58,801 | 60,929 | 63,058 | 64,934 | 66,377 | 67,820 | 69,262 | 70,705 |
| STEP 18 | 57,358 | 59,883 | 62,048 | 64,212 | 66,737 | 68,180 | 69,623 | 71,066 | 72,509 |
| STEP 22 | 58,440 | 60,965 | 63,130 | 65,294 | 68,541 | 69,984 | 71,427 | 72,870 | 74,313 |
| STEP 26 | 59,522 | 62,048 | 64,212 | 66,377 | 70,345 | 71,788 | 73,231 | 74,674 | 76,117 |

## Appendix U

Employee: _____ Position: _____
Evaluator:_____ Date: _____

| A-Demonstrates job knowledge | Outstanding | Meets Expectations | Needs Improvement |
|---|---|---|---|
| 1-Demonstrates knowledge of all aspects of position | | | |
| 2-Effectively applies knowledge to enhance performance | | | |
| 3-Demonstrates proper use and care of equipment | | | |
| 4-Identifies and uses available resources | | | |
| 5-Collects and tracks appropriate data | | | |
| B-Demonstrates Job Competencies | Outstanding | Meets Expectations | Needs Improvement |
| 1-Completes assigned tasks accurately | | | |
| 2-Demonstrates ability to perform job responsibilities | | | |
| 3-Organizes work | | | |
| C-Demonstrates Job Competencies | Outstanding | Meets Expectations | Needs Improvement |
| 1-Manages time efficiently | | | |
| 2-Meets deadlines for tasks assigned | | | |
| 3-Practices safe work habits | | | |
| 4-Stays on task and is productive | | | |
| 5-Follows Supervisor instructions and guidelines | | | |
| 6-Maintains confidentiality | | | |
| 7-Independently seeks and assumes responsibility for tasks | | | |
| 8-Seeks new and/or improved ways to complete tasks | | | |
| 9-Exhibits appropriate dress and grooming | | | |
| 10-Able to prioritize and identify critical job responsibilities | | | |
| 11-Maintains a clean, organized, safe work area | | | |
| D-Maintains Effective Working Relationships | Outstanding | Meets Expectations | Needs Improvement |
| 1-Exhibits positive attitude and actions | | | |
| 2-Is flexible/adaptable to change | | | |
| 3-Is respectful and considerate of others | | | |
| 4-Is punctual | | | |
| 5-Maintains regular attendance (not counting vacation, professional days) | | | |
| 6-Functions effectively as a team member | | | |
| 7-Responds positively to constructive feedback | | | |
| 8-Demonstrates courtesy, effectiveness and efficiency in interactions with others | | | |
| 9-Demonstrates good decision-making skills | | | |

**Appendix U**
**(Continued)**

| E-Professional Growth and Development | Outstanding | Meets Expectations | Needs Improvement |
|---|---|---|---|
| 1-Participates in learning opportunities | | | |
| 2-Willingly takes on additional and appropriate job duties when needed or requested | | | |
| 3-Recognizes when assistance is needed and requests it | | | |

Outstanding: Consistent exemplary performance, including in demanding situations or circumstances
Meets Expectations: Competent performance in most situations and circumstances
Needs Improvement: Improvement needed in key areas

| Supervisor's Comments: |
|---|
| Staff Member's Comments: |

SIGNATURE: Your signature on this form shows only that you received a copy of this report and your supervisor discussed it with you. It does not mean you agree with this evaluation. If you wish, you may submit an explanatory statement that will be filed with this evaluation. Additional materials must be submitted within ten (10) days.

Employee's Signature _____ Date: _____

Evaluator's Signature _____ Date: _____

ASHLAND COUNTY-WEST HOLMES JOINT VOCATIONAL SCHOOL DISTRICT
1783 State Route 60, Ashland, OH 44805-9377

## SALARY SCHEDULE - SECRETARIAL

| STEP | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| 0 | 13.31 | 13.58 | 13.75 |
| 1 | 13.55 | 13.82 | 13.99 |
| 2 | 13.78 | 14.06 | 14.23 |
| 3 | 13.99 | 14.27 | 14.45 |
| 4 | 14.23 | 14.51 | 14.69 |
| 5 | 14.45 | 14.74 | 14.92 |
| 6 | 14.67 | 14.97 | 15.16 |
| 7 | 14.91 | 15.21 | 15.40 |
| 8 | 15.12 | 15.42 | 15.62 |
| 9 | 15.36 | 15.66 | 15.86 |
| 10 | 15.58 | 15.89 | 16.09 |
| 12 | 15.80 | 16.12 | 16.32 |
| 14 | 16.04 | 16.36 | 16.56 |
| 16 | 16.25 | 16.57 | 16.78 |
| 18 | 16.48 | 16.81 | 17.02 |
| 20 | 16.71 | 17.04 | 17.25 |
| 22 | 16.93 | 17.27 | 17.49 |
| 24 | 17.16 | 17.51 | 17.73 |
| 26 | 17.39 | 17.74 | 17.96 |

NOTE: 9.5 & 10 month contract includes 6 paid holidays: Labor Day, Thanksgiving Day Christmas Day, New Year's Day, Martin Luther King Day, and Memorial Day

12 month contract add 2 paid holidays: Fourth of July & Christmas Eve

12 month contract = 260 days
10 month contract = 200 days
9.5 month contract = 190 days

**Appendix W**

ASHLAND COUNTY-WEST HOLMES JVSD
1783 State Route 60, Ashland, OH 44805-9377

## SALARY SCHEDULE - ESEA* QUALIFIED AIDES

*Elementary and Secondary Education Act

| STEP | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| 0 | 12.83 | 13.09 | 13.25 |
| 1 | 13.04 | 13.30 | 13.46 |
| 2 | 13.22 | 13.48 | 13.65 |
| 3 | 13.42 | 13.69 | 13.86 |
| 4 | 13.60 | 13.87 | 14.05 |
| 5 | 13.80 | 14.08 | 14.25 |
| 6 | 13.98 | 14.26 | 14.44 |
| 7 | 14.19 | 14.47 | 14.65 |
| 8 | 14.38 | 14.66 | 14.85 |
| 9 | 14.59 | 14.88 | 15.07 |
| 10 | 14.78 | 15.08 | 15.27 |
| 12 | 14.98 | 15.28 | 15.47 |
| 14 | 15.17 | 15.48 | 15.67 |
| 16 | 15.37 | 15.67 | 15.87 |
| 18 | 15.56 | 15.87 | 16.07 |
| 20 | 15.75 | 16.06 | 16.27 |
| 22 | 15.94 | 16.26 | 16.46 |
| 24 | 16.13 | 16.46 | 16.66 |
| 26 | 16.32 | 16.65 | 16.86 |

License + Bachelors = Additional $0.32 per hour  License + Masters = Additional $0.64 per hour

NOTE: 9 month contract includes 6 paid holidays: Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Martin Luther King Day, and Memorial Day.

120 day contract does not include Memorial Day holiday

ESEA Qualified Aides: 190 days 184 days
155 days 120 days

**Appendix X**

ASHLAND COUNTY-WEST HOLMES JVSD
1783 State Route 60, Ashland, OH 44805-9377

## SALARY SCHEDULE - TEACHER AIDES

| STEP | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| 0 | 11.58 | 11.81 | 11.96 |
| 1 | 11.76 | 11.99 | 12.14 |
| 2 | 11.96 | 12.20 | 12.35 |
| 3 | 12.14 | 12.38 | 12.54 |
| 4 | 12.34 | 12.59 | 12.75 |
| 5 | 12.53 | 12.78 | 12.94 |
| 6 | 12.73 | 12.98 | 13.14 |
| 7 | 12.91 | 13.17 | 13.33 |
| 8 | 13.11 | 13.37 | 13.54 |
| 9 | 13.29 | 13.56 | 13.73 |
| 10 | 13.49 | 13.76 | 13.94 |
| 12 | 13.67 | 13.95 | 14.12 |
| 14 | 13.88 | 14.15 | 14.33 |
| 16 | 14.06 | 14.34 | 14.52 |
| 18 | 14.26 | 14.54 | 14.73 |
| 20 | 14.45 | 14.74 | 14.92 |
| 22 | 14.64 | 14.94 | 15.12 |
| 24 | 14.83 | 15.13 | 15.32 |
| 26 | 15.03 | 15.33 | 15.52 |

NOTE: 9 and 10 month contract includes 6 paid holidays: Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Martin Luther King Day and Memorial Day
12 month contract add 2 paid holidays: Fourth of July & Christmas Eve

Clerical Aide Positions: 12 month contract - 260 days
10 month contract - 200 days

Teacher Aide Positions: 9 month contract - 155 days
9 month contract - 120 days

**Appendix Y**

ASHLAND COUNTY-WEST HOLMES JVSD
1783 State Route 60, Ashland, OH 44805-9377

## SALARY SCHEDULE - CUSTODIAL

| STEP | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| 0 | 13.65 | 13.93 | 14.10 |
| 1 | 13.91 | 14.19 | 14.36 |
| 2 | 14.16 | 14.45 | 14.63 |
| 3 | 14.40 | 14.69 | 14.87 |
| 4 | 14.65 | 14.95 | 15.13 |
| 5 | 14.91 | 15.21 | 15.40 |
| 6 | 15.14 | 15.45 | 15.64 |
| 7 | 15.40 | 15.71 | 15.90 |
| 8 | 15.65 | 15.97 | 16.17 |
| 9 | 15.90 | 16.22 | 16.42 |
| 10 | 16.14 | 16.47 | 16.67 |
| 12 | 16.35 | 16.67 | 16.88 |
| 14 | 16.55 | 16.88 | 17.09 |
| 16 | 16.76 | 17.10 | 17.31 |
| 18 | 16.95 | 17.29 | 17.51 |
| 20 | 17.16 | 17.51 | 17.73 |
| 22 | 17.37 | 17.71 | 17.94 |
| 24 | 17.57 | 17.92 | 18.14 |
| 26 | 17.77 | 18.13 | 18.35 |

NOTE: 12 month contract includes 8 paid holidays: Labor Day, Thanksgiving Day, Christmas Eve, Christmas Day, New Year's Day, Martin Luther King Day, Memorial Day AND Fourth of July

12 month contract - 260 days

2nd / 3rd shift Custodians = $0.10 per hour additional

Maintenance - $0.50 per hour additional

**Appendix Z**

ASHLAND COUNTY-WEST HOLMES JVSD
1783 State Route 60, Ashland, OH 44805-9377

## SALARY SCHEDULE
## CAFETERIA AIDE / CLEANING ASSISTANT/AIDE

| STEP | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| 0 | 11.18 | 11.41 | 11.55 |
| 1 | 11.37 | 11.59 | 11.74 |
| 2 | 11.57 | 11.80 | 11.95 |
| 3 | 11.75 | 11.98 | 12.13 |
| 4 | 11.95 | 12.19 | 12.34 |
| 5 | 12.13 | 12.37 | 12.53 |
| 6 | 12.33 | 12.58 | 12.74 |
| 7 | 12.51 | 12.76 | 12.92 |
| 8 | 12.72 | 12.97 | 13.13 |
| 9 | 12.90 | 13.16 | 13.32 |
| 10 | 13.10 | 13.36 | 13.53 |
| 12 | 13.28 | 13.55 | 13.72 |
| 14 | 13.48 | 13.75 | 13.92 |
| 16 | 13.66 | 13.94 | 14.11 |
| 18 | 13.87 | 14.14 | 14.32 |
| 20 | 14.05 | 14.33 | 14.51 |
| 22 | 14.25 | 14.53 | 14.72 |
| 24 | 14.44 | 14.73 | 14.91 |
| 26 | 14.63 | 14.92 | 15.11 |

NOTE: 9 month contract includes 6 paid holidays: Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Martin Luther King Day, and Memorial Day

Cafeteria Aide Positions: 9 month contract - 188 days

Cleaning Assistant/Aide: 10 month contract - 200 days
2nd / 3rd shifts receive $0.10 per hour additional

# ASHLAND COUNTY - WEST HOLMES J.V.S.D. ASHLAND OH

**Health Benefit Summary Plan Description**
**7670-00-412079**

**Revised 07-01-2017**

BENEFITS ADMINISTERED BY

UMR

A UnitedHealthcare Company

TRANSPLANT SCHEDULE OF BENEFITS ..... 9
OUT-OF-POCKET EXPENSES AND MAXIMUMS ..... 10
ELIGIBILITY AND ENROLLMENT ..... 12
SPECIAL ENROLLMENT PROVISION ..... 16
TERMINATION ..... 18
COBRA CONTINUATION OF COVERAGE ..... 20
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ..... 28
PROVIDER NETWORK ..... 29
COVERED MEDICAL BENEFITS ..... 31
HOME HEALTH CARE BENEFITS ..... 42
TRANSPLANT BENEFITS ..... 43
PRESCRIPTION DRUG BENEFITS ..... 46
HEARING AID BENEFITS ..... 47
MENTAL HEALTH BENEFITS ..... 48
SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS ..... 50
CARE MANAGEMENT ..... 52
COORDINATION OF BENEFITS ..... 54
RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET ..... 58
GENERAL EXCLUSIONS ..... 61
CLAIMS AND APPEAL PROCEDURES ..... 67
FRAUD ..... 76
OTHER FEDERAL PROVISIONS ..... 77
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION ..... 79
STATEMENT OF ERISA RIGHTS ..... 83

PLAN AMENDMENT AND TERMINATION INFORMATION ..... 85

GLOSSARY OF TERMS ..... 86

**ASHLAND COUNTY - WEST HOLMES J.V.S.D.**

**GROUP HEALTH BENEFIT PLAN**

**SUMMARY PLAN DESCRIPTION**

**INTRODUCTION**

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the ASHLAND COUNTY - WEST HOLMES J.V.S.D. Health Benefit Plan (the "Plan"). You are a valued Employee of ASHLAND COUNTY - WEST HOLMES J.V.S.D., and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

ASHLAND COUNTY - WEST HOLMES J.V.S.D. is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and AdvancePCS/Caremark for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document. It is being furnished to You in accordance with ERISA.

This document becomes effective on January 1, 2015.

## PLAN INFORMATION

| | |
|---|---|
| **Plan Name** | ASHLAND COUNTY - WEST HOLMES J.V.S.D. GROUP BENEFIT PLAN |
| **Name And Address Of Employer** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805 |
| **Name, Address, And Phone Number Of Plan Administrator** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805<br>419-289-3313 |
| **Named Fiduciary** | ASHLAND COUNTY - WEST HOLMES J.V.S.D. |
| **Employer Identification Number Assigned By The IRS** | 34-1089984 |
| **Plan Number Assigned By The Plan** | 501 |
| **Type Of Benefit Plan Provided** | Self-funded Health and Welfare Plan providing group health benefits. |
| **Type Of Administration** | The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims. |
| **Name And Address Of Agent For Service Of Legal Process** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805<br><br>Service of legal process may also be made upon the Plan Administrator. |
| **Funding Of The Plan** | Employer and Employee Contributions<br><br>Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer. |
| **Collective Bargaining Provisions** | The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of each agreement may be obtained upon written request to the Plan Administrator, and each agreement is available for examination. |
| **Benefit Plan Year** | Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year. |
| **ERISA Plan Year** | August 1 through July 31 |

| | |
|---|---|
| **ERISA And Other Federal Compliance** | It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict. |
| **Discretionary Authority** | The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and, further, means that the Covered Person consents to the limited standard and scope of review afforded under law. |

## MEDICAL SCHEDULE OF BENEFITS

**Benefit Plan(s) 001, 003**

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible Per Calendar Year:** | | |
| • Per Person | $250 | $500 |
| • Per Family | $500 | $1,000 |
| **Plan Participation Rate, Unless Otherwise Stated Below:** | | |
| • Paid By Plan After Satisfaction Of Deductible | 80% | 60% |
| **Annual Participation Out-Of-Pocket Maximum:** | | |
| ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** | | |
| • Per Person | $750 | $1,500 |
| • Per Family | Not Applicable | Not Applicable |
| **Annual Copay Out-Of-Pocket Maximum:** | | |
| • Per Person | $6,350 | Unlimited |
| • Per Family | $12,700 | Unlimited |
| **Annual Total Out-Of-Pocket Maximum (Includes Deductible):** | | |
| • Per Person | $6,350 | Unlimited |
| • Per Family | $12,700 | Unlimited |
| **Ambulance Transportation:** | | |
| • Paid By Plan After In-Network Deductible | 80% | 80% |
| **Breast Pumps:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Chiropractic Services:** | | |
| • Paid By Plan After Deductible | 80% | 60% |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Contraceptive Methods And Contraceptive Counseling Approved By The FDA:** | | No Benefit |
| **For Men:** | | |
| • Paid By Plan After Deductible | 80% | |
| **For Women:** | | |
| • Paid By Plan | 100%<br>(Deductible Waived) | |
| **Durable Medical Equipment:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Emergency Services / Treatment:** | | |
| **Urgent Care:** | | |
| • Co-pay Per Visit | $75 | Not Applicable |
| • Paid By Plan After Deductible | 100%<br>(Deductible Waived) | 60% |
| **True Emergency Room / Emergency Physicians:** | | |
| • Paid By Plan After In-Network Deductible | 80% | 80% |
| **Non-True Emergency Room / Emergency Physicians:** | | |
| • Co-pay Per Visit<br>(Waived If Admitted As Inpatient Within 24 Hours Or If Due To An Accidental Injury Or Medical Emergency) | $200 | $200 |
| • Paid By Plan After Deductible | 80% | 60% |
| **Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:** | | |
| • Maximum Days Per Calendar Year | 60 Days | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Home Health Care Benefits:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.*** | | |
| **Hospice Care Benefits:** | | |
| **Hospice Services:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Bereavement Counseling:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Respite Care:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Hospital Outpatient Cardiac Rehabilitation Program:** | | |
| • Maximum Benefit Per Calendar Year | $1,000 | |
| • Paid By Plan After Deductible | 80% | 60% |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Hospital Services:** | | |
| **Pre-Admission Testing:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Outpatient Services / Outpatient Physician Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Outpatient Imaging Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Outpatient Lab And X-Ray Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Outpatient Surgery / Surgeon Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Maternity:** | | |
| **Routine Prenatal Services:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Non-Routine Prenatal Services, Delivery, And Postnatal Care:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:** | | |
| **Inpatient Services / Physician Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Residential Treatment:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Outpatient Or Partial Hospitalization Services And Physician Charges:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Office Visit:** | | |
| • Co-pay Per Visit | $25 | Not Applicable |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Physician Office Visit:** | | |
| **Office Visit:** | | |
| • Co-pay Per Visit | $25 | Not Applicable |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Physician Office Services:** | | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:** | | |
| **Preventive / Routine Physical Exams At Appropriate Ages:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Immunizations:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Mammograms And Breast Exams:** | | |
| • Maximum Exams Per Calendar Year | 1 Exam | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Pelvic Exams And Pap Tests:** | | |
| • Maximum Exams Per Calendar Year | 1 Exam | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine PSA Test And Prostate Exams:** | | |
| From Age 40 | | |
| • Maximum Exams Per Calendar Year | 1 Exam | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Screenings / Services At Appropriate Ages And Gender:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Autism Screening:** | | |
| From Age 0 To 21 | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:** | | |
| From Age 40 | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |
| **Preventive / Routine Hearing Exams:** | | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 60% |

| | | |
|---|---|---|
| **Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:**<br>• Paid By Plan After Deductible | 100%<br>(Deductible Waived) | 60% |
| **Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:**<br>• Paid By Plan After Deductible | 100%<br>(Deductible Waived) | 60% |
| **In Addition, The Following Preventive / Routine Services Are Covered For Women:**<br>➢ **Treatment For Gestational Diabetes**<br>➢ **Papillomavirus DNA Testing**<br>➢ **Counseling For Sexually Transmitted Infections (Provided Annually)***<br>➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)***<br>➢ **Breastfeeding Support, Supplies, And Counseling**<br>➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***<br>• Paid By Plan After Deductible<br><br>***These Services May Also Apply To Men.** | 100%<br>(Deductible Waived) | 60% |
| **Sterilizations:**<br><br>**For Men:**<br>• Paid By Plan After Deductible | 80% | 60% |
| **For Women:**<br>• Paid By Plan After Deductible | 100%<br>(Deductible Waived) | 60% |
| **Temporomandibular Joint Disorder Benefits:**<br>• Paid By Plan After Deductible | 80% | 60% |
| **Therapy Services:**<br><br>**Occupational / Physical / Speech Outpatient Hospital And Office Therapy:**<br>• Paid By Plan After Deductible | 80% | 60% |
| **Massage Therapy:**<br>• Maximum Visits Per Calendar Year | 12 Visits | |
| • Paid By Plan After Deductible | 80% | 60% |
| **Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:**<br>• Maximum Benefit Per Calendar Year | $500 | |
| • Paid By Plan | 100%<br>(Deductible Waived) | 100%<br>(Deductible Waived) |
| **All Other Covered Expenses:**<br>• Paid By Plan After Deductible | 80% | 60% |

| TRANSPLANT SCHEDULE OF BENEFITS<br>Benefit Plan(s) 001, 003 | |
|---|---|
| **Transplant Services At A Designated Transplant Facility:** | |
| **Transplant Services:**<br>• Paid By Plan After Deductible | <br>80% |
| **Travel And Housing:**<br>• Maximum Benefit Per Transplant<br>• Paid By Plan | <br>$10,000<br>100% (Deductible Waived) |
| Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant. | |

## OUT-OF-POCKET EXPENSES AND MAXIMUMS

### CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

### DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual Deductible for that year, will also be applied toward the individual Deductible requirement for the next Plan Year.

### PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

### ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do apply toward the medical out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Out-of-Network Co-pays for Prescription products.
- Out-of-network individual and family Deductibles.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

**NO FORGIVENESS OF OUT-OF-POCKET EXPENSES**

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

## ELIGIBILITY AND ENROLLMENT

### ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

### ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - Any other relative or individual unless explicitly covered by this Plan;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

**NON-DUPLICATION OF COVERAGE:** Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

**RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS:** The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

**EXTENDED COVERAGE FOR DEPENDENT CHILDREN**

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan can ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

**IMPORTANT**: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

**EFFECTIVE DATE OF EMPLOYEE'S COVERAGE**

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month following Your date of hire; or
- If You apply later than 30 days following Your date of hire, You will be considered a Late Enrollee. If You are a Late Enrollee, Your coverage will become effective September 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees.)
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

**EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS**

Your Dependent's coverage will be effective on the later of:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- September 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 30 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

**ANNUAL OPEN ENROLLMENT PERIOD**

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will not be considered Late Enrollees. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be September 1 following the annual open enrollment period.

## SPECIAL ENROLLMENT PROVISION
Under the Health Insurance Portability and Accountability Act

This Plan gives each eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

### LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other health coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and
- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents' coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

### NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

**CHANGE IN FAMILY STATUS**

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 30 calendar days of the marriage, birth, adoption, or Placement for Adoption.

**EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION**

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

## TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

### EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to 12 months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

### YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment Section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

**RESCISSION OF COVERAGE**

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative

**REINSTATEMENT OF COVERAGE**

If Your coverage ends due to termination of employment and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee.

If Your coverage ends due to leave of absence, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You are eligible for coverage on the first day of the month following the date You again qualify for eligibility under this Plan.

Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

## COBRA CONTINUATION OF COVERAGE

**Important.** Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

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

**The COBRA Administrator for this Plan is: UMR**

### INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

### COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

| Qualifying Event | Length of Continuation |
|---|---|
| • Your employment ends for any reason other than Your gross misconduct | up to 18 months |
| • Your hours of employment are reduced | up to 18 months |

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

| Qualifying Event | Length of Continuation |
|---|---|
| • Your spouse dies | up to 36 months |
| • Your spouse's hours of employment are reduced | up to 18 months |
| • Your spouse's employment ends for any reason other than his or her gross misconduct | up to 18 months |
| • Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both) | up to 36 months |
| • You become divorced or legally separated from Your spouse | up to 36 months |

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

| Qualifying Event | Length of Continuation |
|---|---|
| • The parent-Employee dies | up to 36 months |
| • The parent-Employee's employment ends for any reason other than his or her gross misconduct | up to 18 months |
| • The parent-Employee's hours of employment are reduced | up to 18 months |
| • The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both) | up to 36 months |
| • The parents become divorced or legally separated | up to 36 months |
| • The Child stops being eligible for coverage under the plan as a Dependent | up to 36 months |

**Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.**

**COBRA NOTICE PROCEDURES**

**THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION**

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

**Send all notices or other information required to be provided by this Summary Plan Description in writing to:**

**UMR**
**COBRA ADMINISTRATION**
**PO BOX 1206**
**WAUSAU WI 54402-1206**
**Phone Number: (800) 207-1824**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

**COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS**

**EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT**

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

**EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT**

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

**MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE**

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

**PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS**

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

**PAYMENT FOR CONTINUATION COVERAGE**

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

**Note: Payment will not be considered made if a check is returned for non-sufficient funds.**

**A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA**

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.
- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

**LENGTH OF CONTINUATION COVERAGE**

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

**THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE**

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

**Social Security Disability Determination (For Employees and Dependents)**: A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the 18-month period within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

**Second Qualifying Events: (Dependents Only)** If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

**COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE**

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**EARLY TERMINATION OF COBRA CONTINUATION**

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

**SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)**

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

**DEFINITIONS**

**Qualified Beneficiary** means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

**Qualifying Event** means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

**Loss of Coverage** means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

**IF YOU HAVE QUESTIONS**

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
ASHLAND COUNTY - WEST HOLMES J.V.S.D.
1783 STATE RTE 60
ASHLAND OH 44805

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

### INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

### COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- a period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

### USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

### PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

### EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

## PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  0L – UnitedHealthcare Choice Plus

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  XZ – First Health Shared Savings
  AL – First Health

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

**The program for Transplant Services at Designated Transplant Facilities is:**

**OptumHealth**

### EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

**Provider Directory Information**

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

**TRANSITIONAL CARE**

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator but which are not considered at the In-Network benefit level by the current claims administrator may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the Effective Date of the Plan.
- Post-acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral health – any previous treatment.

You or Your Dependent must call UMR within 90 days prior to the Effective Date or within 90 days after the Effective Date to see if You or Your Dependent are eligible for this benefit.

The In-Network benefit level may continue for 90 days, despite the fact that these expenses are no longer considered In-Network due to provider termination from the network. In order to be eligible, You or Your Dependent must have been, and must continue to be, under a treatment plan by a provider who was a member of the participating network.

You or Your Dependent must complete a Transition of Care form within 30 days of the date the provider leaves the network and submit the form to Your Plan Administrator to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

## COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

1. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

2. **Acupuncture Treatment.**

3. **Allergy Treatment** including: Injections, testing and serum.

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically-appropriate Hospital.

5. **Anesthetics and Their Administration.**

6. **Autism Spectrum Disorders (ASD) Treatment,** when Medical Necessity is met.

   (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

   ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy.

   Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license.

   Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

   Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

7. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

8. **Breast Reductions** if Medically Necessary.

9. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

10. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.

11. **Cardiac Rehabilitation** programs (when Medically Necessary), if referred by a Physician, for patients who have certain cardiac conditions including, but not limited to, the following:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Covered services include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

12. **Cataract or Aphakia Surgery** as well as surgically implanted protective lenses following such a procedure.

13. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

14. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

15. **Cleft Palate and Cleft Lip,** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

16. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

17. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

18. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

19. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
- Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

20. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

21. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as any other Illness.

22. **Durable Medical Equipment** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs including batteries or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - when necessary because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement for artificial limbs, crutches, braces, and other medical appliances are excluded under the Plan except in the case of Dependent Children when the Physician certifies that such replacement is necessary. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

23. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

24. **Emergency Services Provided in a Foreign Country,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office.

25. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

26. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

27. **Genetic Counseling** based on Medical Necessity.

28. **Genetic Testing** when Medically Necessary (see below).

    Genetic Testing MUST meet the following requirements:

    The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

    And must meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicate a genetic cause.
    - The patient meets defined criteria that place them at high genetic risk for the condition.

    Generally, genetic testing is not covered for:

    - Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
    - Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing)
    - Test is considered Experimental or Investigational.

29. **Hearing Services** include:

    - Exams, tests, services and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids when due to accidental Injury occurring while Plan is in effect.

30. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

31. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:
    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's immediate family members when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.
    - **Respite Care** to provide temporary relief for 5 days per month to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

32. **Hospital Outpatient Cardiac Rehabilitation Program**

    This benefit will only be payable if all of the following conditions have been met:

    - The Covered Person has myocardial infarction, has had coronary bypass surgery, has stable angina pectoris; angioplasty; or a heart transplant;
    - The Covered Person starts his cardiac rehabilitation program within twelve (12) months after discharge from a Hospital stay that is due to one of the above conditions; and
    - The cardiac rehabilitation program is rendered in the Hospital's Outpatient department or in a Medicare-approved facility for cardiac rehabilitation.

33. **Hospital Services (Includes Inpatient Services, Surgical Centers and Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

34. **Hospital Services (Outpatient).**

35. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

36. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

    Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

37. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

38. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

39. **Massage Therapy.** (See Therapy Services below)

40. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.

41. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

42. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

43. **Nursery and Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

44. **Nutritional Counseling** if Medically Necessary.

45. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician, and are the sole source of nutrition or are part of a chemotherapy regimen.

46. **Occupational Therapy.** (See Therapy Services below)

47. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.

- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Excision of exostosis of jaws and hard palate.

48. **Orthognathic, Prognathic and Maxillofacial Surgery** when Medically Necessary.

49. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

50. **Oxygen and Its Administration.**

51. **Pharmacological Medical Case Management** (Medication management and lab charges).

52. **Physical Therapy.** (See Therapy Services below)

53. **Physician Services** for covered benefits.

54. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

55. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

56. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under the applicable law:

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus; and
  - Screening and counseling for interpersonal and domestic violence.

  Please visit the following links for additional information:

  https://www.healthcare.gov/preventive-care-benefits/
  https://www.healthcare.gov/preventive-care-children/
  https://www.healthcare.gov/preventive-care-women/

57. **Prosthetic Devices.** The initial purchase, fitting and repair of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair must also be recommended by the attending Physician. In all cases, repairs due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan. Charges for replacements for artificial limbs, crutches, braces, and other medical appliances are not covered under the Plan except in the case of Dependent Children when the Physician certifies that such replacement is necessary.

58. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly consistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*, including the *National Cancer Institute (NCI);*
  - *Centers for Disease Control and Prevention (CDC);*
  - *Agency for Healthcare Research and Quality (AHRQ);*
  - *Centers for Medicare and Medicaid Services (CMS);*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veteran's Administration (VA);*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense*, or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health; and*
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration;*
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

59. **Radiation Therapy and Chemotherapy.**

60. **Radiology and Interpretation Charges.**

61. **Reconstructive Surgery** includes:

    - Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore bodily function that has been impaired by a congenital illness if Medically Necessary or anomaly, by an Accident, or by an infection or other disease of the involved part.

62. **Respiratory Therapy.** (See Therapy Services below)

63. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

64. **Sleep Disorders** if Medically Necessary.

65. **Sleep Studies.**

66. **Speech Therapy.** (See Therapy Services below)

67. **Sterilizations.**

68. **Substance Use Disorder Services** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD).

69. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

70. **Temporomandibular Joint Disorder (TMJ) Services** includes:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

71. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
    - **Massage therapy** by a Qualified chiropractor, a Qualified massage therapist (MT), a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

72. **Tobacco Addiction:** Services, treatment or supplies related to addiction to or dependency on nicotine.

73. **Transplant Services** (Refer to Transplant section of this SPD).

74. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

75. **Wigs (Cranial Prostheses), Toupees, Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

76. **X-ray Services** for covered benefits.

## HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge for the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

### EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

## TRANSPLANT BENEFITS

**Refer To Care Management section of this SPD for prior authorization requirements**

### DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

**Approved Transplant Services** means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

**Designated Transplant Facility** means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

**Organ and Tissue Acquisition/Procurement** means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

**Stem Cell Transplant** includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

### BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

### COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

**SECOND OPINION**

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

**ADDITIONAL PROVISIONS** (Applies to a Designated Transplant Facility Only)

**TRAVEL EXPENSES** (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

**TRANSPLANT EXCLUSIONS**

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

## PRESCRIPTION DRUG BENEFITS
Administered by AdvancePCS/Caremark

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your Employer with any questions related to this coverage or service.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or not their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether or not election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

**Covered Drugs**

Your Prescription Drug benefit provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a Prescription." Your pharmacist or the prescribing Physician can verify coverage for a drug by contacting the Pharmacy Benefit Manager (PBM) at the number on Your Prescription ID card. A complete list of covered and excluded drugs may be available on the Pharmacy Benefit Manager's website. If You are unable to access the website, Your employer will provide a copy upon request at no charge.

**How To Use The Prescription Drug Card**

Present Your ID card and the Prescription to a Participating Pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the appropriate Co-pay amount, if applicable.

If You are without Your prescription ID card or if You are at a non-Participating Pharmacy, You may be required to pay for the Prescription and submit a claim to the PBM. Please contact the PBM or Your employer for information on how to submit a claim.

**Mail Order Drug Service**

If You are using an ongoing Prescription drug, You may purchase that drug on a mail order basis. Most drugs covered by the PBM may be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

There may be a Co-pay for mail order Prescriptions.

Mail order Prescriptions should be sent to the PBM. Order forms may be available on the PBM's website or from Your employer. All Prescriptions will be mailed directly to Your home.

A directory of Participating Pharmacies is available on the PBM's website. You will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a separate document from this SPD. The directory contains the names, addresses, and phone numbers of the pharmacies that are part of the PBM's program.

## HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC at its toll-free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct him or her to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services not covered under the Plan out-of-pocket prior to the delivery of services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact EPIC directly at its toll-free number or write to: EPIC Hearing Services, 3191 W. Temple Ave. Ste. 200, Pomona, CA 91768.

## MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

### COVERED BENEFITS

**Inpatient Services** means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

**Residential Treatment** means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community-based residential facility or group home.)

**Day Treatment (Partial Hospitalization)** means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

**Outpatient Therapy Services** are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

### ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

**MENTAL HEALTH EXCLUSIONS**

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.
- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
  - Personality disorders; or
  - Sexual/gender identity disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).
- Services for biofeedback.

## SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate as applicable.

### COVERED BENEFITS

**Inpatient Services** means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

**Residential Treatment** means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

**Day Treatment (Partial Hospitalization)** means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

**Outpatient Therapy Services** are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use and chemical dependency disorders.

### ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- Services, treatment, or supplies related to addiction to or dependency on nicotine.

**SUBSTANCE USE DISORDER EXCLUSIONS**

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

## CARE MANAGEMENT

### Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

**Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual.** However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

### UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

### DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

**Prior Authorization** is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

**Utilization Management** means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

### SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Management Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Organ and tissue transplants.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

**Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).**

**PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION**

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $200 may be applied per admission if a Covered Person receives services but does not obtain the required Prior Authorization.

**The phone number to call for Prior Authorization is listed on the back of the Plan identification card.**

The fact that a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

**Medical Director Oversight**. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

**Case Management Referrals**. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. Information is easily passed from utilization management to case management through our fully integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

**Retrospective Review**. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

**Case Management**

**Case Management** Services are designed to identify catastrophic and complex Illnesses, transplants, and trauma cases. UMR Care Management's nurse case managers identify, coordinate, and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during the prior authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician, and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

## COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See the order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

### ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a Dependent and another plan as an Employee, member, or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active Employee (or Dependent of an active Employee), and is also covered under another plan as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee), the plan that covers the person as an active Employee (or Dependent of an active Employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an Employee, member, subscriber, or retiree the longest is primary.

- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

**MEDICARE**

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payments on Medicare Part B services as though Medicare Part B was actually in effect.

**ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE**

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse has retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as his or her Primary Plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Covered Person is enrolled in Medicare.

**TRICARE**

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

**REIMBURSEMENT TO THIRD PARTY ORGANIZATION**

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

**RIGHT OF RECOVERY**

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **3D Mammograms**, unless covered elsewhere in this SPD.
2. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.
3. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
4. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy.**
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.
9. **Autism Services:** Applied Behavioral Analysis (ABA) Therapy.
10. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.
11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.
12. **Biofeedback Services.**
13. **Blood:** Blood donor expenses.
14. **Blood Pressure Cuffs / Monitors.**
15. **Breast Pumps** unless covered elsewhere in this SPD.
16. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
17. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.
18. **Claims** received later than 12 months from the date of service.
19. **Contraceptive Products and Counseling** unless covered elsewhere in this SPD.

20. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

21. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

22. **Custodial Care** as defined in the Glossary of Terms of this SPD.

23. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

24. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy that are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

25. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

26. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

27. **Employment / Workers' Compensation:** An illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, where required by state law.

28. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

29. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

30. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

31. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Benefits section of this SPD.

32. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

33. **Family Planning:** Consultation for family planning.

34. **Financial Counseling.**

35. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

36. **Foot Care (Podiatry):** Routine foot care.

37. **Foreign Coverage for Medical Care Expenses Which Includes Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.

38. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.

39. **Genetic Testing** unless covered elsewhere in this SPD.

40. **Growth Hormones.**

41. **Hearing Services:** Implantable hearing devices unless covered elsewhere in this SPD.

42. **Home Births** and associated costs.

43. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

44. **Infertility Treatment:**

    - Fertility tests.
    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

45. **Lamaze Classes** or other child birth classes.

46. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

47. **Liposuction** regardless of purpose.

48. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

49. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

50. **Marriage Counseling.**

51. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

52. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

53. **Nocturnal Enuresis Alarm** (Bed wetting).

54. **Non-Custom-Molded Shoe Inserts.**

55. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

56. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

57. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

58. **Nutrition Counseling** unless covered elsewhere in this SPD.

59. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

60. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

61. **Palliative Foot Care.**

62. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.

63. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

64. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

65. **Preventive / Routine Care Services** unless covered elsewhere in this SPD.

66. **Private Duty Nursing Services.**

67. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

68. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

69. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

70. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

71. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

72. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

73. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

74. **Services** that should legally be provided by a school.

75. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

76. **Sex Therapy.**

77. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

78. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

79. **Standby Surgeon Charges.**

80. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

81. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

82. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.

83. **Telemedicine - Telephone or Internet Consultations.**

84. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this SPD.

85. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

86. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

87. **Vision Care** unless covered elsewhere in this SPD.

88. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

89. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

90. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

91. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

92. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

**The Plan does not limit a Covered Person's right to choose his or her own medical care.** If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

## CLAIMS AND APPEAL PROCEDURES

### REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

**Pre-Determination**

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

### TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to obtain approval from the Plan ***before*** obtaining the medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  **Note that this Plan does not require prior authorization for urgent or Emergency care claims;** however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

### PERSONAL REPRESENTATIVE

**Personal Representative** means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

**PROCEDURES FOR SUBMITTING CLAIMS**

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

**TIMELY FILING**

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

**INCORRECTLY FILED CLAIMS** (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

**HOW HEALTH BENEFITS ARE CALCULATED**

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

**Fee Schedule**: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

**Negotiated Rate**: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

**Usual And Customary (U&C)** is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90$^{th}$ percentile. See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

**NOTIFICATION OF BENEFIT DETERMINATION**

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

**TIMELINES FOR INITIAL BENEFIT DETERMINATION**

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care Claims: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

**CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS**

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational or Unproven.
- Other reasons as stated elsewhere in this SPD.

**ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)**

**Adverse Benefit Determination** means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

**APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS**

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

**First Level of Appeal**: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

**Second Level of Appeal**: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If you have any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (i.e. to appoint a Personal Representative), or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under Section 502(a) of ERISA.

**Appeals should be sent within the prescribed time period as stated above to the following address(es):**

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Send Pharmacy appeals to:
AdvancePCS/Caremark
9501 E SHEA BLVD
SCOTTSDALE AZ 85040

**TIME PERIODS FOR MAKING DECISIONS ON APPEALS**

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

**RIGHT TO EXTERNAL REVIEW**

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You, or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

**LEGAL ACTIONS FOLLOWING APPEALS**

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

**PHYSICAL EXAMINATION AND AUTOPSY**

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

**RIGHT TO REQUEST OVERPAYMENTS**

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

## FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

## OTHER FEDERAL PROVISIONS

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

### QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

### NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**This group health Plan also complies with the provisions of the:**

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

## HIPAA ADMINISTRATIVE SIMPLIFICATION
## MEDICAL PRIVACY AND SECURITY PROVISION

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Treasurer

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

**DEFINITIONS**

**Administrative Simplification** is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;

- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

**Business Associate (BA) in relationship to a Covered Entity (CE)** means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

**Covered Entity (CE)** is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

**Designated Record Set** means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

**Disclose or Disclosure** is the release or divulgence of information by an entity to persons or organizations outside that entity.

**Electronic Protected Health Information (Electronic PHI)** is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

**Health Care Operations** are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

**Individually Identifiable Health Information** is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or there is reasonable basis to believe the information can be used to identify the Covered Person.

**Payment** means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

**Plan Administrative Functions** means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

**Plan Sponsor** means Your employer.

**Privacy Official** is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

**Protected Health Information (PHI)** is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

**Treatment** is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

**Use** means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

### RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

### CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

### PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

### NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

### ENFORCING COVERED PERSONS' RIGHTS

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

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

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

**ASSISTANCE WITH QUESTIONS**

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

## PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

### COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

### DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post-tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

### NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

## GLOSSARY OF TERMS

**Accident** means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

**Activities of Daily Living (ADL)** means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

**Acupuncture** means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

**Adverse Benefit Determination** means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

**Alternate Facility** means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

**Ambulance Transportation** means professional ground or air Ambulance Transportation in an Emergency situation, or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

**Ancillary Services** means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

**Birthing Center** means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

**Child (Children)** means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

**Close Relative** means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

**Co-pay** means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

**COBRA** means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

**Cosmetic Treatment** means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

**Covered Expense** means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

**Covered Person** means an Employee or Dependent who is enrolled under this Plan.

**Custodial Care** means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

**Deductible** means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

**Dependent** – see the Eligibility and Enrollment section of this SPD.

**Developmental Delays** means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delays may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

**Durable Medical Equipment** means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

**Effective Date** means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

**Emergency** means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

**Employee** – see the Eligibility and Enrollment section of this SPD.

**Enrollment Date** means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

**Essential Health Benefit** means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

**Experimental, Investigational, or Unproven** means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

**Extended Care Facility** means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

**Home Health Care** means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

**Home Health Care Plan** means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

**Hospice Care** means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

**Hospice Care Provider** means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

**Hospital** means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

**Illness** means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

**Imaging** means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

**Incurred** means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

**Independent Contractor** means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

**Infertility Treatment** means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

**Injury** means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

**Inpatient** means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

**Learning Disability** means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

**Legal Guardianship / Legal Guardian** means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

**Life-Threatening Disease or Condition** means a condition likely to cause death within one year of the request for treatment.

**Manipulation** means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

**Maximum Benefit** means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

**Medically Necessary / Medical Necessity** means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease, or symptoms

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

**Medicare** means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

**Mental Health Disorder** means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

**Multiple Surgical Procedures** means that more than one surgical procedure is performed during the same period of anesthesia.

**Negotiated Rate** means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

**Non-Essential Health Benefit** means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

**Orthognathic Condition** means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

**Orthotic Appliance** means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

**Outpatient** means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

**Palliative Foot Care** means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

**Pediatric Services** means services provided to individuals under the age of 19.

**Physician** means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

**Placed for Adoption or Placement for Adoption** means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

**Plan** means the ASHLAND COUNTY - WEST HOLMES J.V.S.D. Group Health Benefit Plan.

**Plan Participation** means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

**Plan Sponsor** means an employer who sponsors a group health plan.

**Prescription** means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

**Preventive / Routine Care** means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

**Prudent Layperson** means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

**QMCSO** means a Qualified Medical Child Support Order in accordance with applicable law.

**Qualified** means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

**Qualified Provider** means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

**Reconstructive Surgery** means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

**Surgical Center** means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

**Telemedicine** means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.

**Temporomandibular Joint Disorder (TMJ)** means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

**Terminal Illness or Terminally Ill** means a life expectancy of about six months.

**Third Party Administrator (TPA)** means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

**Totally Disabled** means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Disease – Clinical Modification manual (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - "V" codes.

**Urgent Care** means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

**Usual and Customary** means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

**You / Your** means the Employee.

# ASHLAND COUNTY - WEST HOLMES J.V.S.D. ASHLAND OH

**Dental Benefit Summary Plan Description**
**7670-02-412079**

**Revised 07-01-2017**

BENEFITS ADMINISTERED BY

UMR

A UnitedHealthcare Company

## Table of Contents

INTRODUCTION ..... 1
PLAN INFORMATION ..... 2
SCHEDULE OF BENEFITS ..... 4
OUT-OF-POCKET EXPENSES AND MAXIMUMS ..... 5
ELIGIBILITY AND ENROLLMENT ..... 6
SPECIAL ENROLLMENT PROVISION ..... 10
TERMINATION ..... 12
COBRA CONTINUATION OF COVERAGE ..... 14
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ..... 22
ALTERNATE BENEFITS PROVISION ..... 23
PRE-TREATMENT ESTIMATE OF BENEFITS ..... 24
COVERED EXPENSES ..... 25
ORTHODONTIC BENEFITS PROVISION ..... 38
COORDINATION OF BENEFITS ..... 41
RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET ..... 44
GENERAL EXCLUSIONS ..... 47
CLAIMS AND APPEAL PROCEDURES ..... 49
FRAUD ..... 56
OTHER FEDERAL PROVISIONS ..... 57
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION ..... 58
STATEMENT OF ERISA RIGHTS ..... 62
PLAN AMENDMENT AND TERMINATION INFORMATION ..... 64
GLOSSARY OF TERMS ..... 65

## ASHLAND COUNTY - WEST HOLMES J.V.S.D.

## GROUP DENTAL BENEFIT PLAN

## SUMMARY PLAN DESCRIPTION

### INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the ASHLAND COUNTY - WEST HOLMES J.V.S.D. Dental Benefit Plan (the "Plan"). You are a valued Employee of ASHLAND COUNTY - WEST HOLMES J.V.S.D., and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

ASHLAND COUNTY - WEST HOLMES J.V.S.D. is named the Plan Administrator for this group dental Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and handle other duties for this self-funded Plan. UMR, as the Third Party Administrator, does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with capital letters, even though it normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this group dental Plan.

Each Individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan Document. Therefore it will be referred to as both the SPD and the Plan Document. It is being furnished to You in accordance with ERISA.

This document becomes effective on January 1, 2015.

## PLAN INFORMATION

| | |
|---|---|
| **Plan Name** | ASHLAND COUNTY - WEST HOLMES J.V.S.D. GROUP BENEFIT PLAN |
| **Name And Address Of Employer** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805 |
| **Name, Address, And Phone Number Of Plan Administrator** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805<br>419-289-3313 |
| **Named Fiduciary** | ASHLAND COUNTY - WEST HOLMES J.V.S.D. |
| **Employer Identification Number Assigned By The IRS** | 34-1089984 |
| **Plan Number Assigned By The Plan** | 502 |
| **Type Of Benefit Plan Provided** | Self-funded Health and Welfare Plan providing group dental benefits. |
| **Type Of Administration** | The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims. |
| **Name And Address Of Agent For Service Of Legal Process** | ASHLAND COUNTY - WEST HOLMES J.V.S.D.<br>1783 STATE RTE 60<br>ASHLAND OH 44805<br><br>Services of legal process may also be made upon the Plan Administrator. |
| **Funding Of The Plan** | Employer and Employee Contributions<br><br>Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer. |
| **Collective Bargaining Provisions** | The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of each agreement may be obtained upon written request to the Plan Administrator, and each agreement is available for examination. |
| **Benefit Plan Year** | Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year. |
| **ERISA Plan Year** | August 1 through July 31 |

| | |
|---|---|
| **ERISA And Other Federal Compliance** | It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict. |
| **Discretionary Authority** | The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this Summary Plan Description (SPD), and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary, capricious, or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and, further means that the Covered Person consents to the limited standard and scope of review afforded under law. |

## SCHEDULE OF BENEFITS

### Benefit Plan 001

Benefits for You and Your Dependents are listed below.

| SUMMARY OF BENEFITS | | |
|---|---|---|
| **Deductibles Per Calendar Year**<br>• Combined Basic And Major Services | **Individual**<br>$50 | **Family**<br>$150 |
| **Maximums**<br>• Calendar Year Benefit Maximum, Including Preventive and Diagnostic Services, Basic Services and Major Services<br>• Lifetime Orthodontic Maximum | **Individual**<br>$1,000<br>$1,500 | |
| **Participation Percentage**<br>• Preventive and Diagnostic Services (Deductible Waived)<br>• Basic Services<br>• Major Services<br>• Orthodontic Services (Deductible Waived) | **The Plan Pays**<br>100%<br>80%<br>50%<br>50% | |

## OUT-OF-POCKET EXPENSES AND MAXIMUMS

### DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year.

### PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable.

### ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Deductible, if applicable, and Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Legal fees and interest charged by a provider.
- The difference between the provider's contracted fee for the service that was actually provided and the fee for the alternate benefit that the Plan approved.

  For example, if the provider placed a resin (white) filling in Your tooth, but an amalgam (silver) filling would have been sufficient to restore the tooth, You will need to pay the difference between the cost of the resin filling and the cost of the amalgam filling.

### INDIVIDUAL CALENDAR YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual dental Calendar Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

### NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

## ELIGIBILITY AND ENROLLMENT

### ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

### ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full- time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse of the opposite sex, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 23rd birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 23 as of the date of such placement;

- A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).

- A Dependent does not include the following:
  - A foster Child;
  - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - Any other relative or individual unless explicitly covered by this Plan;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Note: An Employee must be covered under this Plan in order for Dependents to quality for and obtain coverage.

**NON-DUPLICATION OF COVERAGE:** Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

**RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS:** The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

**EXTENDED COVERAGE FOR DEPENDENT CHILDREN**

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 23rd birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 23 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 23 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

**IMPORTANT:** It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any dental claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

**EFFECTIVE DATE OF EMPLOYEE'S COVERAGE**

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month following Your date of hire; or
- If You apply later than 30 days following Your date of hire, You will be considered a Late Enrollee. If You are a Late Enrollee, Your coverage will become effective September 1 following Your application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees.)
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth in the Special Enrollment Provision section if application is made within 31 days of the event.

**EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS**

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- September 1 following Your application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision section, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

**ANNUAL OPEN ENROLLMENT PERIOD**

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will not be considered Late Enrollees. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be September 1 following the annual open enrollment period.

## SPECIAL ENROLLMENT PROVISION
Under the Health Insurance Portability and Accountability Act

This Plan gives an eligible person special enrollment rights if the person experiences a loss of other dental coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

### LOSS OF DENTAL COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience is a loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan was offered; and
- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group dental plan or dental insurance policy; and
- The coverage under the other group dental plan or dental insurance policy was:
  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for dental coverage under this Plan due to loss of dental coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

### NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

**CHANGE IN FAMILY STATUS**

Current Employees and their Dependents, COBRA qualified beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for dental coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 31 calendar days of the marriage, birth, adoption, or Placement for Adoption.

**EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION**

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

## TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

### EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to 12 months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

### YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The last day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

**REINSTATEMENT OF COVERAGE**

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

If Your coverage ends due to leave of absence, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You are eligible for coverage on the first day of the month following the date You again qualify for eligibility under this Plan.

Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

## COBRA CONTINUATION OF COVERAGE

**Important**. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

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

**The COBRA Administrator for this Plan is: UMR**

### INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including dental benefits) beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

### COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

| Qualifying Event | Length of Continuation |
|---|---|
| • Your employment ends for any reason other than Your gross misconduct | up to 18 months |
| • Your hours of employment are reduced | up to 18 months |

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

| Qualifying Event | Length of Continuation |
|---|---|
| • Your spouse dies | up to 36 months |
| • Your spouse's hours of employment are reduced | up to 18 months |
| • Your spouse's employment ends for any reason other than his or her gross misconduct | up to 18 months |
| • Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both) | up to 36 months |
| • You become divorced or legally separated from Your spouse | up to 36 months |

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

| Qualifying Event | Length of Continuation |
|---|---|
| • The parent-Employee dies | up to 36 months |
| • The parent-Employee's employment ends for any reason other than his or her gross misconduct | up to 18 months |
| • The parent-Employee's hours of employment are reduced | up to 18 months |
| • The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both) | up to 36 months |
| • The parents become divorced or legally separated | up to 36 months |
| • The Child stops being eligible for coverage under the plan as a Dependent | up to 36 months |

**Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.**

**COBRA NOTICE PROCEDURES**

**THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION**

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

**Send all notices or other information required to be provided by this Summary Plan Description in writing to:**

**UMR**
**COBRA ADMINISTRATION**
**PO BOX 1206**
**WAUSAU WI 54402-1206**
**Phone Number: (800) 207-1824**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

**COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS**

**EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT**

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

**EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT**

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

**MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE**

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group dental coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group dental coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group dental coverage will end on the day of the Qualifying Event.

**PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS**

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group dental coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

**PAYMENT FOR CONTINUATION COVERAGE**

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

**Note: Payment will not be considered made if a check is returned for non-sufficient funds.**

**A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA**

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group dental plan.
- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

**LENGTH OF CONTINUATION COVERAGE**

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

**THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE**

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

**Social Security Disability Determination (For Employees and Dependents)**: A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the 18-month period and within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

**Second Qualifying Events: (Dependents Only)** If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

**COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE**

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**EARLY TERMINATION OF COBRA CONTINUATION**

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group dental plan for any Employees. (Note that if the employer terminates the group dental plan that the Qualified Beneficiary is under, but still maintains another group dental plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

**SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)**

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

**DEFINITIONS**

**Qualified Beneficiary** means a person covered by this group dental Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

**Qualifying Event** means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

**Loss of Coverage** means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

**IF YOU HAVE QUESTIONS**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
ASHLAND COUNTY - WEST HOLMES J.V.S.D.
1783 STATE RTE 60
ASHLAND OH 44805

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

### INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

### COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- a period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

### USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

### PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue dental coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

### EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

### ALTERNATE BENEFITS PROVISION

Many dental conditions can be treated in more than one way. This Plan has an "alternate benefits provision" that governs the amount of benefits that this Plan will pay for covered treatments. If a patient chooses a more expensive treatment than is needed to correct a dental condition according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the Dentist decide to use a resin (white) filling, the Plan will base its payment on the Usual and Customary charge or the maximum fee schedule for the amalgam filling. The patient will be responsible for paying the difference in cost.

Alternate benefits will be considered only for those procedures that specifically state "alternate benefit may apply" or "alternate benefit will apply" in the Covered Expenses section of this document.

## PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables a Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what he or she will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits." Here is how the process works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do. This plan of action is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to performing the services. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Obtaining a Pre-Treatment Estimate of Benefits is recommended whenever a Dentist's estimated charge is $200 or more. This feature is not mandatory; however, dental care can be expensive. A Covered Person may want to have an idea of how much this Plan will pay before agreeing to have the treatment performed.

Note: The Pre-Treatment Estimate of Benefits is not a guarantee of payment and is valid for 12 months after the notice date. Benefits are payable if coverage is in effect on the date the services are performed (subject to all Plan provisions) and if the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

## COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule, or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

**General Overview:**

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

## COVERED EXPENSES - PREVENTIVE AND DIAGNOSTIC SERVICES

**Diagnostic Services**

**Clinical Oral Evaluations**

| | |
|---|---|
| D0120 | Periodic oral evaluation (limited to two per calendar year) (not performed in conjunction with orthodontic treatment) |
| D0140 | Limited oral evaluation - problem-focused |
| D0145 | Oral evaluation for a patient under three years of age and counseling with a primary caregiver (limited to two per calendar year) (not performed in conjunction with orthodontic treatment) |
| D0150 | Comprehensive oral evaluation - new or established patient (limited to two per calendar year) (not performed in conjunction with orthodontic treatment) |
| D0160 | Detailed and extensive oral evaluation - problem-focused, by report |
| D0170 | Reevaluation - limited, problem-focused (established patient; not postoperative visit) (limited to two per calendar year) (not performed in conjunction with orthodontic treatment) |
| D0171 | Re-evaluation – post-operative office visit |
| D0180 | Comprehensive periodontal evaluation - new or established patient (limited to two per calendar year) (not performed in conjunction with orthodontic treatment) |
| D0190 | Screening of a patient – a screening, including state or federally mandated screenings, to determine an individual's need to be seen by a Dentist for diagnosis. |
| D0191 | Assessment of a patient - a limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment. |

**X-Rays**

| | |
|---|---|
| D0210 | Intraoral - complete series of radiographic images (including bitewings) (a full-mouth series includes 4 bitewings and 12 or more periapical x-rays) (not performed in conjunction with orthodontic treatment) |
| D0220 | Intraoral - periapical - first radiographic image |
| D0230 | Intraoral - periapical - each additional radiographic image (up to 12) (benefits not to exceed a full-mouth series) |
| D0240 | Intraoral - occlusal radiographic image |
| D0250 | Extraoral - first radiographic image |
| D0260 | Extraoral - each additional radiographic image |
| D0270 | Bitewing - single radiographic image |
| D0272 | Bitewing - two radiographic images |
| D0273 | Bitewing - three radiographic images |
| D0274 | Bitewing - four radiographic images |
| D0277 | Vertical bitewings - seven to eight radiographic images |
| D0290 | Posterior - anterior or lateral skull and facial bone survey radiographic image |
| D0310 | Sialography |

| | |
|---|---|
| D0330 | Panoramic radiographic image, including bitewings and periapicals if necessary - (not performed in conjunction with orthodontic treatment) |
| D0350 | 2D Oral/facial photographic images (including intraoral and extraoral images) (not performed in conjunction with orthodontic treatment) |
| D0351 | 3D photographic image |

**Tests and Laboratory Examinations**

| | |
|---|---|
| D0415 | Collection of microorganisms for culture and sensitivity (may be combined with other services) |
| D0460 | Pulp vitality tests |
| D0470 | Diagnostic casts (not performed in conjunction with orthodontic treatment) |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report |
| D0480 | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report |
| D0486 | Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report |
| D0502 | Other oral pathology procedures, by report |
| D7285 | Incisional biopsy of oral tissue - hard (bone, tooth) |
| D7286 | Incisional biopsy of oral tissue - soft |
| D7287 | Exfoliative cytological sample collection |
| D7288 | Brush biopsy - transepithelial sample collection |

**Other Diagnostic**

| | |
|---|---|
| D9310 | Consultation - diagnostic service provided by Dentist or physician other than requesting Dentist or physician |
| D9430 | Office visit for observation (during regularly scheduled hours; no other services performed) |
| D9440 | Office visit - after regularly scheduled hours |

**Preventive Services**

**Cleaning and Fluoride Treatments**

| | |
|---|---|
| D1110 | Prophylaxis - adult (limited to two per calendar year) |
| D1120 | Prophylaxis - Child (limited to two per calendar year) |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - (limited to one treatment per calendar year) |
| D1208 | Topical application of fluoride, excluding varnish - (limited to one treatment per calendar year) |

**Other Preventive**

| | |
|---|---|
| D1353 | Sealant repair – per tooth |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedures - no operative procedures performed |

**Space Maintenance** - (passive appliances)

| | |
|---|---|
| D1510 | Space maintainer - fixed - unilateral |
| D1515 | Space maintainer - fixed - bilateral |
| D1520 | Space maintainer - removable - unilateral |
| D1525 | Space maintainer - removable - bilateral |
| D1550 | Recement or rebond space maintainer |
| D1555 | Removal of fixed space maintainer |

**Minor Treatment to Control Harmful Habits**

| | |
|---|---|
| D8210 | Removable appliance therapy (not performed in conjunction with orthodontic treatment) |
| D8220 | Fixed appliance therapy (not performed in conjunction with orthodontic treatment) |

**COVERED EXPENSES - BASIC SERVICES**

**Restorations** (including polishing) - multiple restorations on one surface will be considered a single restoration

| | |
|---|---|
| D2140 | Amalgam - one surface, primary or permanent |
| D2150 | Amalgam - two surfaces, primary or permanent |
| D2160 | Amalgam - three surfaces, primary or permanent |
| D2161 | Amalgam - four or more surfaces, primary or permanent |
| D2330 | Resin-based composite - one surface, anterior (teeth 4-13 and 20-29) (alternate benefit may apply) |
| D2331 | Resin-based composite - two surfaces, anterior (teeth 4-13 and 20-29) (alternate benefit may apply) |
| D2332 | Resin-based composite - three surfaces, anterior (teeth 4-13 and 20-29) (alternate benefit may apply) |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle, anterior (teeth 4-13 and 20-29) (alternate benefit may apply) |
| D2390 | Resin-based composite crown, anterior (alternate benefit may apply) |
| D2391 | Resin-based composite - one surface, posterior (alternate benefit may apply) |
| D2392 | Resin-based composite - two surfaces, posterior (alternate benefit may apply) |
| D2393 | Resin-based composite - three surfaces, posterior (alternate benefit may apply) |
| D2394 | Resin-based composite - four or more surfaces, posterior (alternate benefit may apply) |

**Crowns**

| | |
|---|---|
| D2799 | Provisional crown – further treatment or completion of diagnosis necessary prior to final impression |
| D2930 | Prefabricated stainless steel crown - primary tooth |
| D2931 | Prefabricated stainless steel crown - permanent tooth |
| D2932 | Prefabricated resin crown |
| D2933 | Prefabricated stainless steel crown with resin window |
| D2934 | Prefabricated esthetic-coated stainless steel crown - primary tooth |

**Other Basic Restorative Services**

| | |
|---|---|
| D2910 | Recement or rebond inlay, onlay, veneer, or partial coverage restoration |
| D2915 | Recement or rebond indirectly fabricated or prefabricated post and core |
| D2920 | Recement or rebond crown |
| D2940 | Protective restoration |
| D2950 | Core buildup, including any pins |
| D2951 | Pin retention - per tooth, in addition to restoration |
| D2970 | Temporary crown (fractured tooth) |
| D6973 | Core buildup for retainer, including any pins |

**Pulp Capping**

| | |
|---|---|
| D3110 | Pulp cap - direct (excluding final restoration) |
| D3120 | Pulp cap - indirect (excluding final restoration) |

**Pulpotomy**

| | |
|---|---|
| D3220 | Therapeutic pulpotomy - (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament |
| D3221 | Pulpal debridement, primary and permanent teeth |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development |

**Endodontic Therapy on Primary Teeth**

| | |
|---|---|
| D3230 | Pulpal therapy (resorbable filling) anterior, primary tooth - excluding final restoration (alternate benefit may apply) |
| D3240 | Pulpal therapy (resorbable filling) posterior, primary tooth - excluding final restoration (alternate benefit may apply) |

**Endodontic Therapy** (including Treatment Plan, clinical procedures, and follow-up care)

Benefits for root canals in baby teeth are limited to benefits for pulpotomies.

| | |
|---|---|
| D3310 | Anterior (excluding final restoration) |
| D3320 | Bicuspid (excluding final restoration) |
| D3330 | Molar (excluding final restoration) |
| D3331 | Treatment of root canal obstruction; non-surgical access |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth |
| D3333 | Internal root repair of perforation defects |
| D3346 | Retreatment of previous root canal therapy - anterior |
| D3347 | Retreatment of previous root canal therapy - bicuspid |
| D3348 | Retreatment of previous root canal therapy - molar |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11, no benefit if performed within 12 months of root canal. |
| D3352 | Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.). |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.). If over age 11, no benefit if performed within 12 months of root canal. |
| D3354 | Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration - (includes removal of intra-canal medication and procedures necessary to regenerate continued root development and necessary radiographs). If over age 11, no benefit if performed within 12 months of root canal. |

**Apicoectomy/Periapical Services**

| | |
|---|---|
| D3410 | Apicoectomy/periradicular surgery - anterior |
| D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) |
| D3425 | Apicoectomy/periradicular surgery - molar (first root) |
| D3426 | Apicoectomy/periradicular surgery (each additional root) |
| D3430 | Retrograde filling - per root |
| D3450 | Root amputation - per root |

**Other Endodontic Procedures**

| | |
|---|---|
| D3910 | Surgical procedures for isolation of tooth with rubber dam |
| D3920 | Hemisection (including any root removal), not including root canal therapy |
| D3950 | Canal preparation and fitting of preformed dowel or post |

**Surgical Services** (including the usual postoperative services)

| | |
|---|---|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4212 | Gingivectomy or gingivoplasty - to allow access for restorative procedure, per tooth |
| D4230 | Anatomical crown exposure - four or more contiguous teeth per quadrant |
| D4231 | Anatomical crown exposure - one to three teeth per quadrant |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4245 | Apically positioned flap |
| D4249 | Clinical crown lengthening - hard tissue |
| D4260 | Osseous surgery (including evaluation of a full thickness flap and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan |
| D4261 | Osseous surgery (including evaluation of a full thickness flap and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4263 | Bone replacement graft - first site in quadrant |
| D4264 | Bone replacement graft - each additional site in quadrant |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration |
| D4266 | Guided tissue regeneration - resorbable barrier, per site |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) |
| D4268 | Surgical revision procedure, per tooth |
| D4270 | Pedicle soft tissue graft procedure |
| D4273 | Subepithelial connective tissue graft procedures, per tooth |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in same anatomical area) |
| D4275 | Soft tissue allograft |
| D4276 | Combined connective tissue and double pedicle graft, per tooth |
| D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site |

**Other Periodontal Services**

| | |
|---|---|
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - limited to four quadrants per Treatment Plan |
| D4342 | Periodontal scaling and root planing - one to three teeth, per quadrant |
| D4355 | Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis (limited to 6 months from cleaning, or 12 months from any other periodontal services, whichever is later) |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report |
| D4910 | Periodontal maintenance; no benefit if performed within three months of periodontal surgery |
| D4920 | Unscheduled dressing change (by someone other than treating Dentist) |
| D9971 | Odontoplasty, one to two teeth; includes removal of enamel projections (only in conjunction with active periodontal treatment) |

**Adjustment to Dentures** - Separate benefits are allowed only after six months following installation of denture

D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular

**Repairs to Complete Dentures** - Separate benefits are allowed only after six months following installation of denture

D5510 Repair broken complete denture base
D5520 Replace missing or broken tooth - complete denture (each tooth)

**Repairs to Partial Dentures**

D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth

**Denture Rebase Procedures** - Separate benefits for rebase are allowed only after six months following installation of dentures or partials

D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture

**Denture Reline Procedures** - Separate benefits for relines are allowed only after six months following installation of dentures and partials

D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)

**Other Fixed Partial Denture Service**

D6930 Recement or rebond fixed partial denture

**Extractions**

D7111 Extraction, coronal remnants - deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

**Surgical Extractions**

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal - only in conjunction with impacted tooth.

**Other Surgical Procedures**

| | |
|---|---|
| D7260 | Oroantral fistula closure |
| D7261 | Primary closure of a sinus perforation |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth |
| D7280 | Surgical access of an unerupted tooth |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption |
| D7283 | Placement of device to facilitate eruption of impacted tooth |

**Alveoloplasty - Surgical Preparation of Ridge for Dentures**

| | |
|---|---|
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant |

**Vestibuloplasty**

| | |
|---|---|
| D7340 | Vestibuloplasty - ridge extension (secondary epithelialization) |
| D7350 | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue) |

**Surgical Excision of Reactive Inflammatory Lesions**

| | |
|---|---|
| D7410 | Excision of benign lesion up to 1.25 cm |

**Removal of Tumors, Cysts, and Neoplasms**

| | |
|---|---|
| D7411 | Excision of benign lesion up to 1.25 cm |
| D7412 | Excision of benign lesion, complicated |
| D7413 | Excision of malignant lesion up to 1.25 cm |
| D7414 | Excision of malignant lesion greater than 1.25 cm |
| D7415 | Excision of malignant lesion, complicated |
| D7440 | Excision of malignant tumor - lesion diameter up to 1.25 cm |
| D7441 | Excision of malignant tumor - lesion diameter greater than 1.25 cm |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report |

**Excision of Bone Tissue**

| | |
|---|---|
| D7471 | Removal of lateral exostosis (maxilla or mandible) |
| D7472 | Removal of torus palatinus |
| D7473 | Removal of torus mandibularis |
| D7480 | Partial ostectomy (guttering or sacerization) |
| D7485 | Surgical reduction of osseous tuberosity |
| D7490 | Radical resection of maxilla or mandible |
| D7972 | Surgical reduction of fibrous tuberosity |

**Surgical Incision**

| | |
|---|---|
| D7510 | Incision and drainage of abscess - intraoral soft tissue |
| D7511 | Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) |
| D7520 | Incision and drainage of abscess - extraoral soft tissue |
| D7521 | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue |
| D7540 | Removal of reaction-producing foreign bodies - musculoskeletal system |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body |

**Repair and Suturing**

| | |
|---|---|
| D7910 | Suture of recent small wound up to 5 cm |
| D7911 | Complicated suture - up to 5 cm |
| D7912 | Complicated suture - greater than 5 cm |

**Other Repair Procedures**

| | |
|---|---|
| D7921 | Collection and application of autologous blood concentrate product |
| D7951 | Sinus augmentation with bone or bone substitutes (alternate benefit may apply) |
| D7952 | Sinus augmentation via a vertical approach |
| D7960 | Frenulectomy (frenectomy or frenotomy) - separate procedure |
| D7963 | Frenuloplasty |
| D7970 | Excision of hyperplastic tissue - per arch |
| D7971 | Excision of pericoronal gingiva |
| D7980 | Sialolithotomy |
| D7983 | Closure of salivary fistula |

**Anesthesia**

| | |
|---|---|
| D9210 | Local anesthesia not in conjunction with restorative or surgical procedures |
| D9211 | Regional block anesthesia (only with restorative or surgical procedures) |
| D9215 | Local anesthesia (only with restorative or surgical procedures) |
| D9219 | Evaluation for deep sedation or general anesthesia |
| D9220 | Deep sedation/general anesthesia - first 30 minutes when Medically Necessary |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes when Medically Necessary |
| D9241 | Intravenous moderate (conscious) sedation/analgesia - first 30 minutes when Medically Necessary |
| D9242 | Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes when Medically Necessary |
| D9248 | Non-intravenous moderate (conscious) sedation when Medically Necessary |

**Drugs**

| | |
|---|---|
| D9610 | Therapeutic parenteral drug, single administration |
| D9630 | Injections of antibiotic drugs |

**Miscellaneous Services**

| | |
|---|---|
| D9930 | Treatment of complications (post-surgical) - unusual circumstances, by report |
| D9931 | Cleaning and inspection of a removable appliance |

## COVERED EXPENSES - MAJOR SERVICES

**Major Restorative Dentistry –** Inlays/onlays, crowns and other restorative services are covered only when necessitated by decay or traumatic Injury. The alternate benefit of a filling may be applied if there is not enough evidence to support major decay or traumatic Injury. Replacement of these items is limited to once every 5 years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. The alternate benefit of a prefabricated (temporary) crown is allowed for all Covered Persons under age 12.

**Inlay/Onlay Restorations**

| | |
|---|---|
| D2410 | Gold foil - one surface (alternate benefit will apply) |
| D2420 | Gold foil - two surfaces (alternate benefit will apply) |
| D2430 | Gold foil - three surfaces (alternate benefit will apply) |
| D2510 | Inlay - metallic - one surface |
| D2520 | Inlay - metallic - two surfaces |
| D2530 | Inlay - metallic - three or more surfaces |
| D2542 | Onlay - metallic - two surfaces |
| D2543 | Onlay - metallic - three surfaces |
| D2544 | Onlay - metallic - four or more surfaces |
| D2610 | Inlay - porcelain/ceramic - one surface (alternate benefit may apply) |
| D2620 | Inlay - porcelain/ceramic - two surfaces (alternate benefit may apply) |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces (alternate benefit may apply) |
| D2642 | Onlay - porcelain/ceramic - two surfaces (alternate benefit may apply) |
| D2643 | Onlay - porcelain/ceramic - three surfaces (alternate benefit may apply) |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces (alternate benefit may apply) |
| D2650 | Inlay - resin-based composite - one surface |
| D2651 | Inlay - resin-based composite- two surfaces |
| D2652 | Inlay - resin-based composite - three or more surfaces |
| D2662 | Onlay - resin-based composite - two surfaces (alternate benefit may apply) |
| D2663 | Onlay - resin-based composite - three surfaces (alternate benefit may apply) |
| D2664 | Onlay - resin-based composite - four or more surfaces (alternate benefit may apply) |

**Crowns**

| | |
|---|---|
| D2710 | Crown - resin-based composite (indirect) |
| D2712 | Crown - 3/4 resin-based composite (indirect) |
| D2720 | Crown - resin with high noble metal (alternate benefit may apply) |
| D2721 | Crown - resin with predominantly base metal (alternate benefit may apply) |
| D2722 | Crown - resin with noble metal (alternate benefit may apply) |
| D2740 | Crown - porcelain/ceramic substrate (alternate benefit may apply) |
| D2750 | Crown - porcelain fused to high noble metal (alternate benefit may apply) |
| D2751 | Crown - porcelain fused to predominantly base metal (alternate benefit may apply) |
| D2752 | Crown - porcelain fused to noble metal (alternate benefit may apply) |
| D2780 | Crown - 3/4 cast high noble metal |
| D2781 | Crown - 3/4 cast predominantly base metal |
| D2782 | Crown - 3/4 cast noble metal |
| D2783 | Crown - 3/4 porcelain/ceramic |
| D2790 | Crown - full cast high noble metal |
| D2791 | Crown - full cast predominantly base metal |
| D2792 | Crown - full cast noble metal |
| D2794 | Crown - titanium |

**Other Restorative Services**

| | |
|---|---|
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth |
| D2952 | Post and core in addition to crown, indirectly fabricated |
| D2953 | Each additional indirectly fabricated post - same tooth |
| D2954 | Prefabricated post and core in addition to crown |
| D2957 | Each additional prefabricated post - same tooth |
| D2960 | Labial veneer (laminate) - chairside |
| D2961 | Labial veneer (resin laminate) - laboratory |
| D2962 | Labial veneer (porcelain laminate) - laboratory |
| D2971 | Additional procedures to construct new crown under existing partial denture framework |
| D2975 | Coping |
| D2980 | Crown repair, necessitated by restorative material failure, by report |
| D2981 | Inlay repair necessitated by restorative material failure |
| D2982 | Onlay repair necessitated by restorative material failure |
| D2983 | Veneer repair necessitated by restorative material failure |
| D2990 | Resin infiltration of incipient smooth surface lesions |

**Dentures and Partials** - Covered charges for dentures and partial dentures include temporary appliances within 12 months of installation and adjustments and relines within 6 months of installation. Specialized techniques and characterizations are not covered. This benefit is limited to space maintainers for all Covered Persons under age 16. Replacement of these services is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. An alternate benefit may apply if necessary replacement is performed within every five years of installation of the previous appliance.

**Complete Dentures**

| | |
|---|---|
| D5110 | Complete denture - maxillary |
| D5120 | Complete denture - mandibular |
| D5130 | Immediate denture - maxillary |
| D5140 | Immediate denture - mandibular |

**Partial Dentures** (including any conventional clasps, rests, and teeth)

| | |
|---|---|
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) |
| D5225 | Maxillary partial denture - flexible base (including any clasps, rests, and teeth) |
| D5226 | Mandibular partial denture - flexible base (including any clasps, rests, and teeth) |
| D5281 | Removable unilateral partial denture – one-piece cast metal (including clasps and teeth) |

**Repairs to Partial Dentures**

| | |
|---|---|
| D5650 | Add tooth to existing partial denture |
| D5660 | Add clasp to existing partial denture |

**Other Prosthodontic Services**

| | |
|---|---|
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) |
| D5810 | Interim complete denture, maxillary |
| D5811 | Interim complete denture, mandibular |
| D5820 | Interim partial denture, maxillary |
| D5821 | Interim partial denture, mandibular |

D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular
D5860 Overdenture - complete, by report (alternate benefit will apply)
D5861 Overdenture - partial, by report (alternate benefit will apply)
D6985 Pediatric partial denture, fixed (alternate benefit will apply)

**Fixed Partial Denture Pontics** - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied. An alternate benefit applies and is limited to space maintainers for all Covered Persons under age 16.

D6205 Pontic - indirect resin based composite (alternate benefit may apply)
D6210 Pontic - cast high noble metal (alternate benefit may apply)
D6211 Pontic - cast predominantly base metal (alternate benefit may apply)
D6212 Pontic - cast noble metal (alternate benefit may apply)
D6214 Pontic - titanium (alternate benefit may apply)
D6240 Pontic - porcelain fused to high noble metal (alternate benefit may apply)
D6241 Pontic - porcelain fused to predominantly base metal (alternate benefit may apply)
D6242 Pontic - porcelain fused to noble metal (alternate benefit may apply)
D6245 Pontic - porcelain/ceramic (alternate benefit may apply)
D6250 Pontic - resin with high noble metal (alternate benefit may apply)
D6251 Pontic - resin with predominantly base metal (alternate benefit may apply)
D6252 Pontic - resin with noble metal (alternate benefit may apply)
D6253 Provisional pontic further treatment or completion of diagnosis necessary prior to final impression

**Fixed Partial Denture Retainers** - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied. An alternate benefit applies and is limited to a prefabricated (temporary) crown allowed for all Covered Persons under age 16.

D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer – for resin bonded fixed prosthesis
D6600 Inlay - porcelain/ceramic, two surfaces (alternate benefit may apply)
D6601 Inlay - porcelain/ceramic, three or more surfaces (alternate benefit may apply)
D6602 Inlay - cast high noble metal, two surfaces
D6603 Inlay - cast high noble metal, three or more surfaces
D6604 Inlay - cast predominantly base metal, two surfaces
D6605 Inlay - cast predominantly base metal, three or more surfaces
D6606 Inlay - cast noble metal, two surfaces
D6607 Inlay - cast noble metal, three or more surfaces
D6624 Inlay - titanium
D6608 Onlay - porcelain/ceramic, two surfaces (alternate benefit may apply)
D6609 Onlay - porcelain/ceramic, three or more surfaces (alternate benefit may apply)
D6610 Onlay - cast high noble metal, two surfaces
D6611 Onlay - cast high noble metal, three or more surfaces
D6612 Onlay - cast predominantly base metal, two surfaces
D6613 Onlay - cast predominantly base metal, three or more surfaces
D6614 Onlay - cast noble metal, two surfaces
D6615 Onlay - cast noble metal, three or more surfaces
D6634 Onlay - titanium
D6710 Crown - indirect resin based composite (alternate benefit may apply)
D6720 Crown - resin with high noble metal (alternate benefit may apply)
D6721 Crown - resin with predominantly base metal (alternate benefit may apply)
D6722 Crown - resin with noble metal (alternate benefit may apply)

| | |
|---|---|
| D6740 | Crown - porcelain/ceramic (alternate benefit may apply) |
| D6750 | Crown - porcelain fused to high noble metal (alternate benefit may apply) |
| D6751 | Crown - porcelain fused to predominantly base metal (alternate benefit may apply) |
| D6752 | Crown - porcelain fused to noble metal (alternate benefit may apply) |
| D6780 | Crown - 3/4 cast high noble metal |
| D6781 | Crown - 3/4 cast predominantly base metal |
| D6782 | Crown - 3/4 cast noble metal |
| D6783 | Crown - 3/4 porcelain/ceramic (alternate benefit may apply) |
| D6790 | Crown - full cast high noble metal |
| D6791 | Crown - full cast predominantly base metal |
| D6792 | Crown - full cast noble metal |
| D6793 | Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression |
| D6794 | Crown - titanium |

**Other Fixed Partial Denture Services** - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury.

| | |
|---|---|
| D6940 | Stress breaker (only with allowable appliance) |
| D6980 | Fixed partial denture repair, by report necessitated by restorative material failure |
| D9120 | Fixed partial denture sectioning |

## ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures. This benefit is subject to Medical Necessity and all other Plan provisions. Benefits are based on the Usual and Customary charge or the maximum fee schedule.

With respect to each Covered Person, the Lifetime Maximum Benefit payable under this Provision for all covered orthodontic expenses will not exceed the orthodontic Maximum Benefit shown in the Schedule of Benefits.

### ORTHODONTIC PROCEDURE

**Orthodontic Procedure** means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Procedure includes minor treatment to control harmful habits and diagnostic services (casts, consultations, exams, x-rays, and related photos taken by the Dentist).

### ORTHODONTIC TREATMENT PLAN

The Treatment Plan is a Dentist's report, on a form satisfactory to the Plan, that:

- Provides a classification of the malocclusion;
- Recommends and describes necessary treatment by Orthodontic Procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charge for such treatment; and
- Is accompanied by cephalometric x-rays, study models, and such other supporting evidence as the Plan may reasonably require.

### COVERED ORTHODONTIC EXPENSES

In order to be payable, orthodontic treatment must be needed for one or more of the following conditions:

- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

## COVERED EXPENSES - ORTHODONTIC

**Clinical Oral Evaluations**

| | |
|---|---|
| D0120 | Periodic oral evaluation (performed in conjunction with orthodontic treatment) |
| D0150 | Comprehensive oral evaluation - new or established patient (performed in conjunction with orthodontic treatment) |
| D0170 | Reevaluation - limited, problem-focused (established patient; not post-operative visit) (performed in conjunction with orthodontic treatment) |
| D0180 | Comprehensive periodontal evaluation - new or established patient (performed in conjunction with orthodontic treatment) |

**Radiographs/Diagnostic Imaging**

| | |
|---|---|
| D0210 | Intraoral - complete series of radiographic images (including bitewings) (a full-mouth series includes 4 bitewings and 12 or more periapical x-rays) (performed in conjunction with orthodontic treatment) |
| D0330 | Panoramic radiographic image, including bitewings and periapicals if necessary - (performed in conjunction with orthodontic treatment) |
| D0340 | Cephalometric radiographic image |
| D0350 | Oral/facial images (includes intraoral and extraoral images) (performed in conjunction with orthodontic treatment) |

**Tests and Laboratory Examinations**

| | |
|---|---|
| D0470 | Diagnostic casts (performed in conjunction with orthodontic treatment) |

**Other Surgical Procedures**

| | |
|---|---|
| D7291 | Transseptal fiberotomy, supra crestal fiberotomy, by report |

**Limited Orthodontic Treatment**

| | |
|---|---|
| D8010 | Limited orthodontic treatment of the primary dentition |
| D8020 | Limited orthodontic treatment of the transitional dentition |
| D8030 | Limited orthodontic treatment of the adolescent dentition |
| D8040 | Limited orthodontic treatment of the adult dentition |

**Interceptive Orthodontic Treatment**

| | |
|---|---|
| D8050 | Interceptive orthodontic treatment of the primary dentition |
| D8060 | Interceptive orthodontic treatment of the transitional dentition |

**Comprehensive Orthodontic Treatment**

| | |
|---|---|
| D8070 | Comprehensive orthodontic treatment of the transitional dentition |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition |
| D8090 | Comprehensive orthodontic treatment of the adult dentition |

**Minor Treatment to Control Harmful Habits**

| | |
|---|---|
| D8210 | Removable appliance therapy (performed in conjunction with orthodontic treatment) |
| D8220 | Fixed appliance therapy (performed in conjunction with orthodontic treatment) |

**Other Orthodontic Services**

| | |
|---|---|
| D8660 | Pre-orthodontic treatment examination to monitor growth and development |
| D8670 | Periodic orthodontic treatment visit |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) |
| D8690 | Orthodontic treatment (alternative billing to a contract fee) |
| D8691 | Repair of orthodontic appliance |
| D8692 | Replacement of lost or broken retainer (limited to replacement of broken retainer) |
| D8693 | Recement or rebond fixed retainers |

## COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules below determine which plan will pay first (i.e., which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to total of 100% of charges Incurred may be paid between the plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specified disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies. See the order of benefit determination rules (below) for details.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

### ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply.

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments related to dental care are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a Dependent and another plan as an Employee, member, or subscriber, the plan that covers the person as an Employee, member, or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. See continuation coverage below.

- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or Dependent of an active or laid-off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law, and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

**TRICARE**

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

**REIMBURSEMENT TO THIRD PARTY ORGANIZATION**

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

**RIGHT OF RECOVERY**

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

## RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in this SPD as covered dental benefits based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
2. **Appointments Missed:** Appointments the Covered Person did not attend.
3. **Athletic Mouth Guards.**
4. **Before Effective Date and After Termination:** Services, supplies, or expenses Incurred before coverage begins or after coverage ends under this Plan.
5. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including, but not limited to bleaching. This exclusion does not apply to Accidental Dental Injury or to orthodontic services.
6. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony in which the individual is charged.
7. **Denture Duplication.**
8. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.
9. **Employment/Workers' Compensation:** An Illness or Injury arising out of or in the course of, any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy, or contract where required by law.
10. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.
11. **Experimental or Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.
12. **Fractures:** Treatment of fractures not including teeth or alveolar processes.
13. **Implants** and related services.
14. **Interest and Legal Fees.**
15. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.
16. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.
17. **Multiple Surgical and Periodontal Procedures** in the same area. Benefits will be limited to the most extensive and inclusive procedure.

18. **Myofunctional Therapy.**

19. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary.

20. **Orthodontic Services,** unless covered elsewhere in this document.

21. **Orthognathic Surgery,** unless covered elsewhere in this document.

22. **Professionally Recognized Standards:** Procedures that are not necessary and that do not meet professionally-recognized standards of care.

23. **Programs** for oral hygiene or plaque control.

24. **Replacement** of lost, missing, or stolen appliances regardless of any other provision of this Plan.

25. **Self-Inflicted Injuries or Illnesses** unless due to medical conditions (physical or mental) or domestic violence.

26. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

27. **Services Not Furnished By a Dentist or Dental Hygienist** who is acting under a Dentist's supervision and direction, except for x-rays ordered by a Dentist.

28. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."

29. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.

30. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting, or replacing tooth structure lost as a result of abrasion, attrition, or erosion, unless covered elsewhere in this document.

31. **Treatment of Disturbances** of the temporomandibular joint, craniomandibular dysfunctions, myofacial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion also pertains to temporomandibular joint radiographs.

**Benefits not specifically included in the Covered Expenses section of this document are considered excluded.**

## CLAIMS AND APPEAL PROCEDURES

### REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

### PERSONAL REPRESENTATIVE

**Personal Representative** means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

### PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group dental identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider

- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto accident, or another accident (if applicable)
- Assignment of benefits (if applicable)

**TIMELY FILING**

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

**HOW DENTAL BENEFITS ARE CALCULATED**

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group dental Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

**Fee Schedule**: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

**Negotiated Rate**: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

**Usual And Customary (U&C)** is the amount that is usually charged by dental care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile of MDR. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above)

**NOTIFICATION OF BENEFIT DETERMINATION**

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group dental identification card. The provider will receive a similar form for each claim that is submitted.

**TIMELINES FOR INITIAL BENEFIT DETERMINATION**

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

**CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS**

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the dental Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group dental Plan.
- Termination of the group dental Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not covered benefits under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

**ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)**

**Adverse Benefit Determination** means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

**APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS**

If a Covered Person disagrees with the denial of a claim, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

**First Level of Appeal**: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision, and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision, and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

**Second Level of Appeal**: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative) or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

**Appeals should be sent within the prescribed time period as stated above to the following address(es):**

Send dental appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

**TIME PERIODS FOR MAKING DECISIONS ON APPEALS**

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service Claim: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.

**RIGHT TO EXTERNAL REVIEW**

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven Services; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits), or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the time lines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical or dental records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

**LEGAL ACTIONS FOLLOWING APPEALS**

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

**RIGHT TO REQUEST OVERPAYMENTS**

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

## FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek dental treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

## OTHER FEDERAL PROVISIONS

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

### QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

**This group dental Plan also complies with the provisions of the:**

- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.

## HIPAA ADMINISTRATIVE SIMPLIFICATION
## MEDICAL PRIVACY AND SECURITY PROVISION

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Treasurer

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

**DEFINITIONS**

**Administrative Simplification** is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;

- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

**Business Associate (BA) in relationship to a Covered Entity (CE)** means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

**Covered Entity (CE)** is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

**Designated Record Set** means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or dental records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

**Disclose or Disclosure** is the release or divulgence of information by an entity to persons or organizations outside that entity.

**Electronic Protected Health Information (Electronic PHI)** is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

**Health Care Operations** are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

**Individually Identifiable Health Information** is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or there is reasonable basis to believe the information can be used to identify the Covered Person.

**Payment** means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

**Plan Administrative Functions** means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

**Plan Sponsor** means Your employer.

**Privacy Official** is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

**Protected Health Information (PHI)** is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

**Treatment** is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

**Use** means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

**APPENDIX BB**

## STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

### RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

### CONTINUE GROUP DENTAL COVERAGE

Covered Persons have the right to continue dental care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

### PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

### NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

### ENFORCING COVERED PERSONS' RIGHTS

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

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

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

**ASSISTANCE WITH QUESTIONS**

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

## PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

### COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

### DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post-tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

### NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

## GLOSSARY OF TERMS

**Accidental Dental Injury / Injury** means damage to the mouth, teeth, and supporting tissues due directly to a blow from outside the mouth.

**Adverse Benefit Determination** means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

**Calendar Year Maximum Benefit** means the maximum amount of covered benefits payable during a calendar year while a person is covered under this Plan. Once the Calendar Year Maximum Benefit is met, no further covered benefits will be available for the remainder of that calendar year.

**Child (Children)** means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

**Close Relative** means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

**COBRA** means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives a Covered Person the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a qualifying event.

**Covered Expenses** means any expense, or portion thereof, that is Incurred as a result of receiving an eligible benefit under this Plan.

**Covered Person** means an Employee or Dependent who is enrolled under this Plan.

**Deductible** means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the dental care benefits to which it applies.

**Dental Hygienist** means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

**Dentist** means a person who is licensed to practice dentistry, and who is practicing within the scope of such license. The term also includes any physician who furnishes any dental services that such physician is licensed to perform.

**Dependent** – see the Eligibility and Enrollment section of this SPD.

**Effective Date** means the first day of coverage as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

**Emergency Dental Care** means care of a dental condition that is required unexpectedly and immediately because of an Injury or Illness.

**Employee** – see the Eligibility and Enrollment section of this SPD.

**Enrollment Date** means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

**Experimental, Investigational, or Unproven** means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

**Illness** means a bodily disorder, disease, or physical sickness affecting the mouth, teeth, or gums.

**Incurred** means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

**Independent Contractor** means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

**Legal Guardianship / Legal Guardian** means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

**Maximum Benefit** means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

**Medically Necessary / Medical Necessity** means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a dental condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving dental outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, or the Covered Person's family, or for any provider; and
- It is not Experimental, Investigational, cosmetic, or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Dentist has performed, prescribed, recommended, ordered, or approved a service, Treatment Plan, supply, medicine, equipment, or facility, or the fact that such service is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, Treatment Plan, supply, medicine, equipment, or facility Medically Necessary.

**Medicare** means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

**Negotiated Rate** means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

**Pediatric Dental Services** means services provided to individuals under the age of 19.

**Placed for Adoption / Placement for Adoption** means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

**Plan** means the ASHLAND COUNTY - WEST HOLMES J.V.S.D. Group Dental Benefit Plan.

**Plan Participation** means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

**Plan Sponsor** means an employer who sponsors a group dental plan.

**QMSCO** means a Qualified Medical Child Support Order in accordance with applicable law.

**Qualified** means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

**Third Party Administrator (TPA)** means a service provider hired by the Plan to process dental claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

**Totally Disabled** means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in activities of daily living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Diagnosis of one or more of the following conditions is not considered proof of total disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Diseases - Clinical Modification manual (ICD-CM) in the following categories:

- Personality disorders, or
- Sexual/gender identity disorders, or
- Behavior and impulse control disorders, or
- "V" codes.

**Treatment Plan** means the Dentist's report to the Plan that:

- Lists the dental care recommended by the Dentist for the Covered Person; and
- Shows the Dentist's normal fee for each dental procedure; and
- Includes preoperative x-rays and all other diagnostic materials needed by the Plan; and
- Is prepared on a form acceptable to the Plan.

**Usual and Customary** means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

**You / Your** means the Employee.

## Appendix CC

**LIST OF STUDENT ORGANIZATION ACTIVITIES:**

1- A minimum of four (4) monthly program meetings with minutes

2- Fall Advisors meeting**

3- Leadership Conference/Activity

4- Students running for Regional or State Office**

5- In Program Competition**

6- Regional Competitive Event (graded or judged

7- Grading or Judging Event

8- District Competitive Events

9- Banquet/Awards Ceremony**

10- Sponsoring a Regional/District Event**

11- State Competitive Event

12- National Competitive Event

13- Work Force Ready Assessments**

14- Skill Connect Assessments – Perkins IV Employability**

15- Instructor Webinar**

16- Student running for National Office**

17- Fundraiser

18- Community or Public Service project

19- Officer or Leadership book/competition/training

20- Celebrate and promote VSO Week (FFA, Skills, BPA, etc.)**

21- Regional Advisor Responsibility**

22- VSO Camp

23- Coordinate registrations and/or accommodations for off campus events**

24- Other Activities approved by Supervisor**

25- Role of General Skills USA Lead Advisor (Counts as two Activities)

**Asterisks denote those activities which may require additional pre-approval.

**Appendix DD**

## APPROVAL GUIDELINES

1- Activities, other than regular meetings, should be pre-approved by appropriate supervisor.

2- Many activities will be pre-approved through use of normal district forms, i.e. Field Trips, Conference Registration, Attendance at Professional Meeting, Fund Raisers, etc. These signed and approved forms are adequate pre-approval.

3- Taking more than one student to more than one Competitive Event at the same location and on the same date, qualifies as one activity.

4- Coordinators or Lead Advisors should be approved and submitted by the bargaining unit to Administration within the first six weeks of school.

5- Only one credit may be accrued for regular meetings, i.e., eight (8) meetings with minutes do not equal two activity credits.

6- In cases where there is more than one Coordinator or Lead Advisor for an Organization, shared credit for activities must by pre-approved by appropriate supervisor.

**Appendix EE**

**Ashland County-West Holmes Career Center**
**1783 State Route 60, Ashland, OH 44805**

**FORMAT OF MINUTES**

**MEETING MINUTES:** _____
Club Name

**Date and Time:** _____

**Officers Present:** _____ _____

_____ _____

_____ _____

**Others Present:** _____ _____

_____ _____

_____ _____

**Advisors Present:** _____ _____

***ANY MOTIONS MUST INCLUDE THE PERSON WHO MADE THE MOTION, WHO SECONDED THE MOTION AND THE VOTE COUNT***

**Old Business:** _____

_____

_____

_____

_____

_____

_____

**New Business:** _____

_____

_____

_____

_____

_____

_____

_____

_____

**Special Notes:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Officer Signature

_____
Position

_____
Advisor Signature

Ashland County-West Holmes
CAREER CENTER JVSD

**ATTENDANCE INCENTIVE REQUEST FORM**

Printed Name _____

**Personal Leave:**
At the end of my current contract year, I certify that I have the following personal leave balance. I understand that I will receive $95.00 for each **full** day of personal leave not used during the current school year as per the terms of the the current Negotiated Agreement. Please complete the following:

Current School Year: _____ **And,**

_____ **# of full unused personal leave days for the current school year.**

**Sick Leave:**
As per the Negotiated Agreement, bargaining unit members are paid for unused sick leave days as follows:

*$285.00 payment for not using any sick leave during the year*
*$190.00 payment for only using one (1) day of sick leave*
*$95.00 payment for only using two (2) days of sick leave*

_____ **# of sick leave days used during the current school year.**
(To qualify for a payment under this section, this number must be 0,1 or 2)

_____ _____
**Signature** **Date**

**This form is due to the Treasurer by June 30th. Payment will be made on the 2nd pay of July each year.**

Ashland County-West Holmes
CAREER CENTER JVSD

**ATTENDANCE INCENTIVE -12 MONTH SUPPORT PERSONNEL REQUEST FORM**

Printed Name _____

**12 Month Educational Support Personnel:**
Educational Support Personnel are eligible for an additional bonus of $100 if no personal or sick leave days are used during the summer (regular scheduled work days after the last and before the first student day).

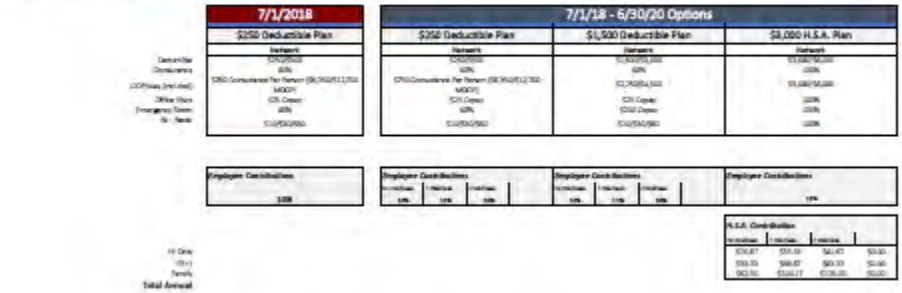
_____ I certify that I used no Personal or Sick leave days during the summer months

_____ _____
Signature Date

**This form is due to the Treasurer by August 31. Payment will be made on the 2nd pay of Sept. each year.**

**Exhibit GG**

Ashland County-West Holmes J.V.S.D.




oswald

# Ashland County-West Holmes JVSD

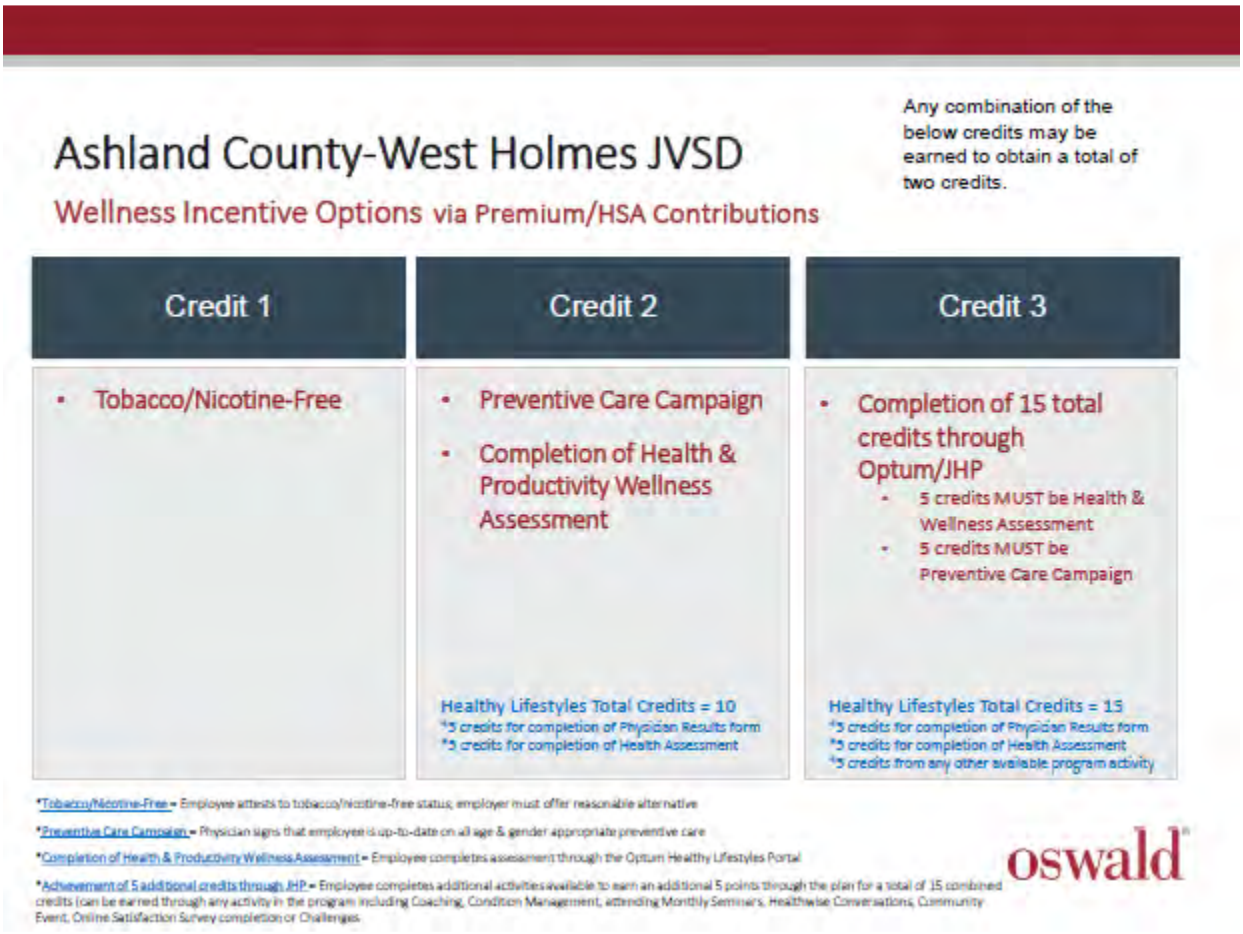
## Wellness Incentive Options via Premium/HSA Contributions

### 2018-2019

| $250 Deductible Plan | $1,500 Deductible Plan | $3,000 H.S.A. Plan |
|---|---|---|
| Employees pay 12% of premium with the option to earn wellness credits:<br>• Credit Level 1 = employee pays 11%<br>• Credit Level 2 = employee pays 10% | Employees pay 12% of premium with the option to earn wellness credits:<br>• Credit Level 1 = employee pays 11%<br>• Credit Level 2 = employee pays 10% | Employees pay 12% of premium<br>The board makes an annual contribution to the Health Savings Accounts of eligible employees:<br>**Annual Overall Board Contributions** |

| | 0 Credits | | 1 Credits | 2 Credits |
|---|---|---|---|---|
| Single | $200 | | $400 | $500 |
| EE + 1 | $400 | | $800 | $1,000 |
| Family | $750 | | $1,250 | $1,500 |

oswald


Ashland County-West Holmes JVSD
Wellness Incentive Options via Premium/HSA Contributions
Any combination of the below credits may be earned to obtain a total of two credits.
Credit 1
Tobacco/Nicotine-Free
Credit 2
Preventive Care Campaign
Completion of Health & Productivity Wellness Assessment
Healthy Lifestyles Total Credits = 10
*5 credits for completion of Physician Results form
*5 credits for completion of Health Assessment
Credit 3
Completion of 15 total credits through Optum/JHP
5 credits MUST be Health & Wellness Assessment
5 credits MUST be Preventive Care Campaign
Healthy Lifestyles Total Credits = 15
*5 credits for completion of Physician Results form
*5 credits for completion of Health Assessment
*5 credits from any other available program activity
*Tobacco/Nicotine-Free = Employee attests to tobacco/nicotine-free status; employer must offer reasonable alternative
*Preventive Care Campaign = Physician signs that employee is up-to-date on all age & gender appropriate preventive care
*Completion of Health & Productivity Wellness Assessment = Employee completes assessment through the Optum Healthy Lifestyles Portal
*Achievement of 5 additional credits through JHP = Employee completes additional activities available to earn an additional 5 points through the plan for a total of 15 combined credits (can be earned through any activity in the program including Coaching, Condition Management, attending Monthly Seminars, Healthwise Conversations, Community Event, Online Satisfaction Survey completion or Challenges
oswald

# Ashland County-West Holmes JVSD

## JHP Wellness Incentive Program

Healthy Lifestyles Program includes the following activities:

| Program Activity | Credit Value | Annual Max |
|---|---|---|
| Health & Productivity Wellness Assessment **REQUIRED** | 5 | 5 |
| Biometric Screening (Physician Results Form) | 5 | 5 |
| Virtual Coaching Milestone (6-week program) | 5 | 15 |
| Lifestyle Coaching (6-month program) | 10 | 10 |
| Healthy Living Condition Management | 10 | 10 |
| Online Monthly Seminars | 1 each | 5 |
| Healthwise Conversations | 1 each | 5 |
| Community Event Form (1 form) | 3 | 3 |
| Online Satisfaction Survey | 2 | 2 |
| Challenge (Fall Fitness, Healthy Hearts, Strike Out Stress) | 5 each | 15 |

*Completion of the Health & Productivity Wellness Assessment is required; employee earns 5 points for completion. Remaining 10 points can be achieved through any available incentive.

oswald

Measurement Period is January 1st – December 31st; reduced rates will apply at next renewal July 1st