

**SCHOOLS RISK AND INSURANCE MANAGEMENT GROUP
HEALTH AND WELFARE PROGRAM**

PROGRAM DOCUMENT

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

This document together with the Master Contracts, the Contract Administrator and/or Participating District Participation Agreements, Regulation No. 3009 Schools Risk and Insurance Management Group Guidelines for the Administration of Coverage Subject to Master Contracts, Regulation No. 3010 Employee Benefits Trust District Administrative Regulations or the Certificates of Coverage identified in this document constitutes the Program.

SCHOOLS RISK AND INSURANCE MANAGEMENT GROUP HEALTH AND WELFARE PROGRAM

Table of Contents

	Page
INTRODUCTION	3
ARTICLE ONE: Definitions and Interpretation.....	3
ARTICLE TWO: Eligibility, Participation and Contributions	8
ARTICLE THREE: Incorporation by Reference; Benefits	10
ARTICLE FOUR: Administration of the Program.....	11
ARTICLE FIVE: Amendments, Terminations and Mergers	16
ARTICLE SIX: Guarantees and Liabilities	17
ARTICLE SEVEN: Claims Procedures.....	18
ARTICLE EIGHT: Adoption by Participating Districts	31
ARTICLE NINE: Miscellaneous	32
EXHIBIT A: PLANS	45
EXHIBIT B: LOOK-BACK PROVISIONS.....	46
EXHIBIT C: PARTICIPATING DISTRICTS ADOPTING PROGRAM	56

SCHOOLS RISK AND INSURANCE MANAGEMENT GROUP HEALTH AND WELFARE PROGRAM

INTRODUCTION

Schools Risk and Insurance Management Group (the “Contract Administrator” or “Program Administrator”) hereby amends and restates in its entirety the Schools Risk and Insurance Management Group Health and Welfare Program (the “Program”). The purpose of the Program is to consolidate in one Program document certain welfare benefit plans (the “Plans”) sponsored by Schools Risk and Insurance Management Group so as to provide uniform administration of such welfare benefits. The Plans are listed in **Exhibit A** to this Program. This Program is effective July 1, 2020 and supersedes any prior Program document.

The insurance contracts, policies and procedures, Regulation No. 3009 Schools Risk and Insurance Management Group Guidelines for the Administration of Coverage Subject to Master Contracts, Regulation No. 3010 Employee Benefits Trust District Administrative Regulations and any other documents making up the Plans are hereby incorporated by reference into this document. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts, if any, or similar arrangements.) These documents in the aggregate serve as a written Program document. Where a conflict of language exists between the Plan and this Program or its Summary Program Description (“SPD”), the Plan will control to the extent such Plan is not inconsistent with applicable Federal law and regulations or unless the Program specifically provides otherwise.

ARTICLE ONE: Definitions and Interpretation

Section 1.1 Definitions.

Where the following words and phrases appear in the Program, they shall have the respective meanings set out below, unless their context clearly indicates otherwise. Capitalized terms not defined in this Program will have the meaning given to them in the applicable documents describing the particular Plan.

- (a) Affordable Care Act means Patient Protection and Affordable Care Act (“ACA”), as amended by the Health Care and Education Reconciliation Act of 2010.
- (b) Applicable Large Employer means, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. In making the Applicable Large Employer determination, all persons/entities treated as a single employer under Code Section 414(b), (c), (m) or (o) are treated as one employer.

- (c) Certificate of Coverage means a document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.
- (d) Claim Fiduciary means any party who has accepted status as a Named Fiduciary in accordance with Section 1.1(o) or (u) below with respect to the determination of the amount of, and entitlement to, benefits under any uninsured Plan.
- (e) Code means the Internal Revenue Code of 1986, as amended.
- (f) Contract Administrator, also known as the Program Administrator, is Schools Risk and Insurance Management Group.
- (g) Dependent means, unless otherwise specifically provided in the Program or in a Plan (to the extent such provisions are in compliance with Federal law), a natural or adopted child, step-child, foster child, child for whom the Employee and/or the Employee's Spouse are the legal guardian or for whom the Employee or Employee's Spouse has legal custody, or any other person specified as such in **Exhibit A**.
- (h) Effective Date of the Program is July 1, 2020, superseding any prior versions of the Program as of such date.
- (i) Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (i)(A) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (i)(B) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not in either (i)(A) or (i)(B) herein, such individual is determined by the Internal Revenue Service ("IRS"), any governmental agency or authority, or a court or agency (including any reclassification by an Employer or in settlement of any claim or action relating to such individual's employment status) to be a common-law employee of the Employer; (ii) any individual who is a former Employee; and (iii) any individual who is a non-resident alien. Notwithstanding the above, any of the individuals listed in the categories (i) through (iii) above, may be included if so specified in **Exhibit A** or are required to be included pursuant to the terms of **Exhibit B** attached hereto. Any Employee subject to a

collective bargaining agreement may be included as an Employee under **Exhibit A** or **Exhibit B** attached hereto.

- (j) Employer is any Participating District that adopts the Program in part or in its whole in accordance with the provisions of Article Eight. The Employer is also known as the Plan Administrator.
- (k) Group Health Plan has the meaning given by section 2791(a) of the Public Health Service Act, which provides that it is an employee welfare benefit plan.
- (l) HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.
- (m) HIPAA-Excepted Coverage is any benefit that is not subject to the HIPAA portability provisions, including accident-only coverage, disability income coverage, liability insurance, worker's compensation, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and retiree-only health plans. HIPAA-Excepted Coverage also includes, under certain circumstances, limited-scope dental or vision benefits as well as long-term care, nursing home care, home health care, or community-based care benefits provided that they are: (i) under a separate policy, certificate or contract of insurance or (ii) otherwise not an integral part of the Group Health Plan (i.e., Participants may decline coverage if claims for the benefits are administered under a contract separate from claims administration for any other benefits under the Group Health Plan). In addition, benefits under a health care flexible spending account and/or health reimbursement arrangement are HIPAA-Excepted Coverage if: (i) the Employer offers other Group Health Plan coverage (not limited to excepted benefits) to Employees and (ii) the maximum benefit payable to any Participant cannot exceed either two times the Participant's salary reduction election for the year or, if greater, \$500 plus the amount of the Participant's salary reduction election. HIPAA-Excepted Coverage also includes "noncoordinated excepted benefits" such as coverage for only a specified disease or illness and hospital indemnity or other fixed indemnity insurance if: (i) the benefits are provided under a separate policy, certificate or contract of insurance; (ii) there is no coordination between the provision of such benefits and any exclusion of benefits under any Group Health Plan maintained by the same plan sponsor; and (iii) the benefits are provided under any Group Health Plan maintained by the same plan sponsor.
- (n) Hour of Service means (i) *Hour of Service*. The term *Hour of Service* means each hour for which an employee is paid, or

entitled to payment, for the performance of duties for the employer; and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)). For rules determining an employee's hours of service, see Section 54.4980H-3. (ii) *Excluded hours*. (A) *Bona fide volunteers*. The term *Hour of Service* does not include any hour for services performed as a bona fide volunteer. (B) *Work-study program*. The term *Hour of Service* does not include any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a *substantially* similar program of a State or political subdivision thereof. (C) *Services outside the United States*. The term *Hour of Service* does not include any hour for services to the extent the compensation for those services constitutes income from sources outside the United States (within the meaning of Sections 861 through 863 and the regulations thereunder). (iii) *Service for other Applicable Large Employer members*. In determining Hours of Service and status as a full-time employee for all purposes under Section 4980H, an Hour of Service for one Applicable Large Employer member is treated as an Hour of Service for all other Applicable Large Employer members for all periods during which the Applicable Large Employer members are part of the same group of employers forming an Applicable Large Employer.

- (o) Named Fiduciary means any person named in the Program as a fiduciary in accordance with Section 1.1(u) below.
- (p) Participant is any individual who has properly enrolled in, and who participates in, a Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate in the Program. Participation requirements are described in **Exhibit A** and may be further described in the individual Plans.
- (q) Participating District means any member of the Schools Risk and Insurance Management Group Employee Benefit Program. The Participating District is also known as the Employer and the Plan Administrator. Participating Districts that have adopted the Program are listed in **Exhibit C**.
- (r) Plan means the specific benefit arrangement identified in **Exhibit A** by which the Program provides welfare benefits. A Plan includes any applicable insurance policies and Certificates of

Coverage relating thereto and may be amended from time to time by the Contract Administrator.

- (s) Plan Administrator is the party identified in the SPD that will perform the duties and responsibilities as detailed in this document and, if applicable the documents of a Plan. The Plan Administrator is also known as the Employer and the Participating District.
- (t) Program means Schools Risk and Insurance Management Group Health and Welfare Program, as amended from time to time.
- (u) Program Fiduciary means that a person (i) exercises any discretionary authority or discretionary control with respect to management of such Program or exercises any authority or control with respect to management or disposition of its assets; (ii) renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such Program, or has authority or responsibility to do so; or (iii) has any discretionary authority or discretionary responsibility in the administration of such Program.
- (v) Program Year For recordkeeping purposes, the Program Year for the Program is the 12 month period beginning on July 1 and ending June 30.
- (w) Premium(s) means the actual premium charge by the insurance carrier with respect to an insured product or the "premium equivalent" amount (i.e., the cost of coverage for the applicable Plan) for non-insured benefits.
- (x) Spouse means an individual who is legally married to an employee.

All other defined terms in the Program shall have the meanings specified in the various Articles of the Program in which they appear.

Section 1.2 Interpretation.

Whenever a noun or pronoun is used in this Program in plural form and there is only one person within the scope of the word so used, or in singular form and there be more than one person within the scope of the word so used, such noun or pronoun shall have a plural or singular meaning as the case may be. Likewise, pronouns of one gender shall include the other gender. The words "herein," "hereof," and "hereunder" shall refer to this Program. Headings are given to the Articles and Sections of the Program only for the purpose of convenience and to make the document easier to read. Headings, numbering, and paragraphing shall not in any case be deemed material or relevant to the interpretation of the Program or its contents.

ARTICLE TWO: Eligibility, Participation and Contributions

Section 2.1 Eligibility.

The eligibility requirements for Participant benefits under the Program are identified in **Exhibit A** and may be set forth in each Plan.

Section 2.2 Enrollment

Each eligible Employee who has satisfied the requirements of Section 2.1, where enrollment is required by the Employer to participate, may become a Participant for a Program Year by enrolling in a Plan in accordance with procedures established by the Plan Administrator for that purpose. For purposes of the Program, references to enrollment shall include telephone enrollment, electronic enrollment, or any other form of enrollment, if and to the extent permitted by the Plan Administrator. Enrollment shall be made at such time and in such manner as the Plan Administrator shall prescribe and shall remain in effect until the first day of the next following plan year. The Plan year for each Plan should be set forth in that Plan and may be different than the Program Year for this Program. As part of such enrollment, the eligible Employee shall agree to make any required contributions towards the cost of such coverage.

An eligible Employee may elect and enroll, where enrollment is required by the Employer to participate, in some or all of the benefits available under a Plan. An eligible Employee may also elect not to participate in a Plan for which annual elections are then being made. Once an eligible Employee is a participant in the Program, the Employee will be given an opportunity to elect and enroll in the benefits for which such Employee has become newly eligible.

If a newly eligible Employee fails to enroll in a Plan which requires enrollment when first eligible, or within 30 days (or, for some employers, 31 days) of the occurrence of a Change in Status (defined in Section 2.4 below) or other event entitling the eligible Employee to an election change under this Article Two, the eligible Employee may not enroll in the Plan until the next following annual open enrollment period. Once made, an enrollment (and the elections made therein) may be revoked or modified during a Plan year only on account of the eligible Employee's termination of employment or the occurrence of an event entitling the eligible Employee to an election change in accordance with this Article 2.

Section 2.3 Participation.

Any individual who is eligible to participate in any Plan and who is properly enrolled in a Plan shall be a Participant in this Program. The participation requirements under the Program are identified in **Exhibit A** and may be set forth in each Plan.

If an Employee previously participated in the Plan and is rehired, such Employee will be eligible to become a Participant on the same terms as if such Employee were a newly hired Employee. Notwithstanding the above, if the Group Health Plan is one offered by an Applicable Large Employer subject to Section 4980H of the ACA, an Employee who resumes providing service to such Applicable Large Employer after a period during which Employee was not credited with any Hours of Service may be treated as having terminated employment and been rehired as a new Employee only if the following

conditions apply: (i) such Employee had no Hours of Service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) such Employee had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of Employee's period of employment. These provisions are intended to comply with Section 4980H of the ACA and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

As to any Plan that is a Group Health Plan (other than one offering only HIPAA-Excepted Coverage), any otherwise eligible Employee must wait no longer than ninety (90) days to begin coverage under such Plan.

With respect to insured benefits, participation may be delayed or otherwise affected as provided under the applicable Certificate of Coverage due to an insurance carrier's imposition of an "actively at work" requirement for certain types of insurance, which provisions may also apply in the case of a rehired Employee. This "actively at work" requirement is not permitted for Group Health Plans (other than ones offering only HIPAA-Excepted Coverage) unless there is an exception for individuals who are absent from work due to a health factor (e.g., individual is out on sick leave on the day coverage would otherwise become effective).

Section 2.4 Election Changes

A Participant may change or revoke their elections during a Plan year on account of the Participant's termination of employment and upon a Change in Status to the extent permitted under the Employer's Code Section 125 cafeteria plan and the applicable Plan, or as required by applicable law. For the purposes of this Section 2.4, the term "Change in Status" means a change in status or other event that permits a mid-year election change, as determined under the Employer's cafeteria plan and the applicable Plan. If the Plan is a Group Health Plan, a Change in Status shall also include the occurrence of a special enrollment event under HIPAA.

Section 2.5 Termination of Participation.

Participation in the Program will terminate on the date an Employee is no longer eligible to participate in every Plan. An Employee may become ineligible for any benefit under the Program if such Employee fails to pay the applicable premiums or meet other requirements of a particular Plan. The provisions for the termination of Participant benefits under the Program are identified in **Exhibit A** and may be set forth in each Plan.

Section 2.6 Contributions.

The cost of the benefits provided through the Plans may be funded in part by Employer contributions and in part by Employee contributions, which may be pre-tax through a cafeteria plan under Code Section 125. In some instances, a Plan may require only the Employer or the Employee to contribute. The Participating District will determine and periodically communicate the Employee's share of the cost of the benefits provided through each Plan, and it may change that determination at any time. The Employer will make its contributions in an amount that in Schools Risk and Insurance Management Group's sole discretion determines is at least sufficient to fund the benefits. The Contract Administrator will pay its contribution and Employee contributions to an insurance

company or, with respect to benefits that are self-funded, will use these contributions to pay benefits directly on behalf of Employees or their eligible family members.

Section 2.7 Look-Back Provisions.

If the Employer has elected to include the optional look-back provisions under the ACA, such provisions may be reflected in **Exhibit B** attached hereto.

Section 2.8 No Eligibility Discrimination Due to Health.

The Program shall not establish rules for eligibility (including continued eligibility) for health benefits for any Employee under the Program that are based on one or more health status-related factors (including health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability) of the Employee or their Dependent.

Section 2.9 No Premium Discrimination Due to Health.

The Program shall not require an Employee (as a condition of enrollment or continued enrollment in the health benefits offered under this Program) to pay a premium or otherwise contribute an amount which exceeds the amount paid by a similarly situated Employee solely due to a health status-related factor (including health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability ((including conditions arising out of acts of domestic violence) and disability)) of the Employee; provided, however, that the rules regarding health status-related factors do not restrict the amount an Employer may charge for coverage or prevent premium discounts or rebates or modified deductibles and co-payments in return for adherence to programs of health promotion and disease prevention.

ARTICLE THREE: Incorporation by Reference; Benefits

Section 3.1 Incorporated Documents.

The Program incorporates the documents, including without limitation any insurance contracts and related Certificates of Coverage, containing the substantive provisions governing the Plans provided under this Program and further identified in **Exhibit A**. If the Plan documents are amended or superseded, the amended or successor documents will automatically become incorporated documents. If there is no provision in an incorporated document corresponding to a provision of this Program, to the extent applicable, the Program provisions will apply to the incorporated document. Where a conflict of language exists between the Plan and this Program, the Plan will control to the extent not inconsistent with Federal law and regulations thereunder or unless the Program specifically provides otherwise.

Section 3.2 Benefits Available.

The benefits available under the Program shall consist of the benefits available under the Plans, including all limitations and exclusions with respect to each Plan's benefits. The benefits available under each Plan are set forth in the Plan documents. The availability of benefits is subject to payment by the Participant of all applicable contributions and

satisfaction of any eligibility or other requirements of a particular Plan. If the Employer provides for a cafeteria plan under Code Section 125, certain benefits thereunder may be paid for by an Employee on a pre-tax basis. If such a cafeteria plan is provided, it will be identified as a funding source in **Exhibit A**.

Section 3.3 Termination of Rights to Benefits.

Any termination of a Participant's coverage under a Plan shall be considered a termination of that same coverage under this Program. An Employee's benefits (and the benefits of their eligible family members including Dependents) will cease when the Employee's participation in the Program terminates. Benefits will also cease upon termination of the Program and certain benefits may cease upon termination of a Plan. Other circumstances can result in the termination of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents in the applicable Exhibits provide additional information.

ARTICLE FOUR: Administration of the Program

Section 4.1 Named Fiduciary.

The Contract Administrator is the "Named Fiduciary" of the Program. With respect to the determination of the amount of, and entitlement to, benefits under any insured Plan, however, the respective insurance company is also a Named Fiduciary under the Program, with the full power to interpret and apply the terms of the Program as they relate to the benefits provided under the applicable insurance policy. The insurance companies providing insured benefits under the Plans are identified in **Exhibit A**. In addition, where any other party has accepted status as a Named Fiduciary, with respect to the determination of the amount of, and entitlement to, benefits under any uninsured Plan, such Named Fiduciary (also referred to as a "Claim Fiduciary") with respect to the applicable Plan is identified in **Exhibit A**.

Section 4.2 Delegation.

The Contract Administrator may delegate to any committee, person, or Employee, officer or agent of Schools Risk and Insurance Management Group or a Participating District any one or more of its powers, functions, duties or responsibilities with respect to the Program. Any such delegation of responsibilities may be amended from time to time in writing by the Contract Administrator and may be revoked in whole or in part at any time by written notice from one party to the other. The provisions of this Section 4.2 control over any inconsistent provisions of any Plan.

Section 4.3 General.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Program or may hold settlor and fiduciary positions with the Program. A Named Fiduciary may designate persons other than the Named Fiduciaries to carry out its fiduciary responsibilities under the Program.

Section 4.4 Interpretation and Findings of Fact.

The Program Administrator shall have the sole and absolute discretion to interpret the provisions of the Program. Each insurance company providing insured benefits under a

Plan, to the extent necessary to pay or adjudicate claims with respect to any Plan for which it provides benefits, shall have sole and absolute discretion to interpret the provisions of the Plan. This includes, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Program or the Plan, determining the rights and status under the Program or the Plan of Participants and other persons, to decide disputes arising under the Program or the Plan, to make factual determinations, and to make any determinations and findings with respect to the benefits payable and the persons entitled to benefits as may be required for the purposes of the Program or the Plan.

Section 4.5 Assistance.

The Program Administrator may employ such clerical, legal, actuarial, accounting, or other assistance or services that it believes are necessary or advisable in connection with the performance of its duties.

Section 4.6 Indemnification.

To the extent permitted by law, the Employer shall indemnify and hold harmless any person serving as the Plan Administrator or partner, manager, officer, or Employee, as the case may be, of Schools Risk and Insurance Management Group or a Participating District, whether such person is acting as a member of a committee or individual who has received delegated authority from the Contract Administrator or Plan Administrator, from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, or lack of good faith. Notwithstanding the above, the indemnification provisions of this section shall not apply to any person (or entity) compensated for providing a fiduciary service (such as an insurance company or third-party administrator who has accepted fiduciary responsibility for claims). The provisions of this Section 4.6 control over any inconsistent provisions of any Plan.

Section 4.7 Insuring and Funding Benefits.

Funding for the Program shall consist of the sum of the funding for all Plans and may include funding through a cafeteria plan which, if available, is identified as a funding source in **Exhibit A**. Schools Risk and Insurance Management Group shall have the right to pay benefits from its general assets, insure any benefits under the Program, and establish any fund or trust for the holding of contributions or payment of benefits under the Program, either as mandated by law or as Schools Risk and Insurance Management Group deems advisable in its sole discretion. In addition, Schools Risk and Insurance Management Group shall have the right in its sole discretion to alter, modify or terminate any method or methods used to fund the payment of benefits under the Program, including, but not limited to, any trust or insurance policy. If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier.

With respect to any insurance company refunds/rebates received by Schools Risk and Insurance Management Group that are subject to the Medical Loss Ratio ("MLR") provisions of the ACA, such refunds/rebates must be treated consistent with the provisions of the ACA and Department of Labor Technical Release 2011-04. The allocation of insurance refunds that are not "Program assets" are to be used, allocated,

and/or distributed among one or more of the Employer(s) as the Contract Administrator in its sole discretion determines appropriate. As to any other amounts, fiduciary decisions by the Contract Administrator are required based on the facts and circumstances relating to such refund. Generally, the following rules will apply (note that these rules do not apply to self-funded plans):

- (a) If the Employer pays the entire premium applicable to the Plan, the entire refund amount will be retained by the Employer;
- (b) If the Participants pay the entire premium applicable to the Plan, the entire refund amount will be used to benefit the Participants;
- (c) If the Employer and Participants shared premiums based on a fixed percentage, the rebate is divided based on percentage;
- (d) If the Employer paid a fixed amount of premiums and Participants paid the rest, the rebate is a Program asset (and must be used for the benefit of the Participants) to the extent it does not exceed total Participant contributions in the relevant MLR period;
- (e) If the Participants paid a fixed amount and the Employer paid the rest, the rebate belongs to the Employer to the extent it does not exceed the total Employer contributions in the relevant MLR period;
- (f) Allocation among Participants of their portion of any refund need not be pro rata and may not include all Participants (e.g., former participants may be excluded where based on a cost-benefit analysis (provided however in all cases the allocation must be based on a reasonable, fair and objective method)); and
- (g) If the rebate is applied toward a benefit enhancement or as an offset to Participants' share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the Participants' share of premiums be reduced over a period of months) should be provided in a written policy.

Despite the general rules previously discussed, the following conditions apply with respect to Program assets:

- (a) A “Program Fiduciary” in all cases must act prudently, solely in the interest of the Program Participants and beneficiaries, and in accordance with the terms of the Program; and
- (b) The use of any refunds for expenses should be limited to those necessary and reasonable expenses (1) paid to a third-party or (2) for reimbursing in-house expenses, but in such case, only upon the advice of outside counsel.

With respect to refunds to Participants of a Group Health Plan, premiums must be allocated among Participants in the same policy.

The following rules will generally apply unless extraordinary circumstances determined by the fiduciary dictate otherwise:

- (a) First, refunds will be used within 90 days of receipt by the Program to reduce future premiums; and
- (b) Second, refunds will be used within 90 days of receipt by the Program to enhance benefits, pay expenses, or make distributions to Participants as determined by the fiduciary after considering all of the facts and circumstances.

In addition, with respect to any other insurance company rebate or similar refund not subject to the MLR rules, the Employer may apply similar rules or any other rules it determines in its sole discretion are advisable under the circumstances, subject to any fiduciary duties it may have.

Section 4.8 Subrogation and Right of Reimbursement.

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

The Program does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Program (including, but not limited to, medical benefits under an automobile insurance policy). If an Employee, Spouse, Dependent, or any other person specified as an “Eligible Non-Employee” in **Exhibit A** (a “Covered Individual”) incurs expenses and receives benefits from the Program or its carrier(s) as a result of an injury or accident caused by the action of a third party, immediately upon payment of any benefits under the Program, the Program shall be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Program.

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

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

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

A Covered Individual (and individuals acting on such Covered Individual's behalf, including without limitation attorneys) shall do nothing to prejudice the Program's subrogation and reimbursement rights and shall, when requested, provide the Program with information and cooperate with the Program in the enforcement of its subrogation and reimbursement rights. It is the Employee's duty, and the duty of individuals acting on the Employee's behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when the Employee gives notice to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Program on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

- (a) informing the Plan Administrator of the action to be taken by the Covered Individual;
- (b) agreeing (in such form and to such documents as the Program may require) to the Program being reimbursed from any recovery from a third

party and subrogated to any right of recovery the Covered Individual has against a third party;

- (c) refraining from action which would prejudice the Program's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Program); and
- (d) cooperating in doing what is reasonably necessary to assist the Program in any recovery.

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

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

ARTICLE FIVE: Amendments, Terminations and Mergers

Section 5.1 Right to Amend.

Schools Risk and Insurance Management Group reserves the right to amend the Program and any Plan from time to time in its sole discretion, including amendments that are retroactive in effect to the extent permitted by law.

Section 5.2 Program Merger.

Schools Risk and Insurance Management Group reserves the right to merge the Program or any Plan at any time in its sole discretion.

Section 5.3 Right to Terminate.

Schools Risk and Insurance Management Group may terminate the Program and any Plan in whole or in part at any time in its sole discretion. In addition, any amounts remaining in the Program at termination shall be distributed as if they were insurance company refunds/rebates and subject to the procedures provided in Section 4.7.

Section 5.4 Payment of Claims Upon Termination.

Upon termination of the Program, the Program shall continue until all pending claims for benefits outstanding as of the date of termination have been paid or otherwise resolved.

ARTICLE SIX: Guarantees and Liabilities

Section 6.1 No Guarantee of Employment.

Nothing contained in the Program shall be construed as a contract of employment between an Employer and an Employee or Participant, or as a right of any Employee or Participant to continue in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of the Employees or Participants, with or without cause, or change the terms and conditions of employment of the Employees or Participants.

Section 6.2 No Guarantee of Non-Taxability.

Neither the Contract Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Program will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Program is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Section 6.3 Withholding Taxes.

To the extent an Employer is required to withhold Federal, state, local or foreign taxes in connection with any payment made to a Participant under a Plan, the Employer shall withhold the amount from the payment as determined by the Employer in its sole discretion.

Section 6.4 Incapacity to Receive Payment.

If the Plan Administrator finds that any Participant entitled to receive benefits under the Program is, at the time such benefits are payable, unable to care for their affairs because of a physical, mental, or legal incompetence, the Plan Administrator may, in its sole discretion, pay the benefits to which the Participant was entitled to one or more persons chosen by the Plan Administrator from among the following: the institution maintaining or responsible for the maintenance of such Participant, their Spouse, their children, or other relative by blood or marriage. Any payment made under these circumstances shall be a complete discharge of all liability under the Program with respect of such payment.

Section 6.5 Severability Provision.

If any provision of the Program or the application of a provision to any circumstance or person is invalid, the remainder of the Program and its application to other circumstances or persons shall not be affected thereby.

Section 6.6 Right of Recovery.

The Plan Administrator shall have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment, including from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under the applicable Contract Administrator and/or Participating District-sponsored benefit program.

ARTICLE SEVEN: Claims Procedures

Section 7.1 Benefits Administered by Insurers or TPAs.

Claims for benefits that are insured or administered by a third party administrator shall be filed in accordance with the specific procedures contained in the insurance policies, Plans or the third party administrative services agreement. The address of the individual insurance company providing benefits and/or third party administrator (if any) that reviews claims made under a Plan is set forth in **Exhibit A** to the extent required by law or provided by the Contract Administrator. All other general claims or requests, including claims for eligibility to participate in the Program, should be directed to the Contract Administrator.

Section 7.2 Personal Representative.

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

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

- (a) A power of attorney for health care purposes, notarized by a Notary Public;
- (b) A court order appointing the person as the conservator or guardian of the individual; or
- (c) Evidence that an individual is the parent of a minor child.

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

Section 7.3 General Claims Procedure.

Subject to Section 7.4 governing claims made under a Plan that is a Group Health Plan, and Section 7.5, governing claims made under a Plan providing disability benefits, the following procedures will be followed if a claim under a Plan is denied, in whole or in part. These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") (or any dependent care assistance plan offered thereunder).

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

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

- (b) Within 60 days after notification of a claim denial (or the date of a deemed denial), a claimant may appeal the denial by submitting a written request for reconsideration of the claim to the Contract Administrator, which includes the reasons why the claimant feels the claim is valid and the reasons why the claimant thinks the claim should not be denied. Before submitting an appeal request, the claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. If the claimant fails to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it under these procedures or in a court or any other venue. Documents, records, written comments, and other information in support of the appeal should accompany any appeal request. The Contract Administrator will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Contract Administrator due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Contract Administrator expects to render a decision. The Contract Administrator's response will explain the reason for the decision with specific reference to the provisions of the Program on which the decision is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement about the claimant's right to bring a civil action.
- (c) The Contract Administrator has the sole discretion to interpret the appropriate Program provisions, and such decisions are conclusive and binding. For purposes of the provisions in this Article Seven, the term "Contract Administrator" will include the applicable insurance company or other party that has accepted its fiduciary responsibility to make claim determinations (consistent with Section 4.1 above as a Claim Fiduciary) with respect to the applicable Plan.
- (d) To the extent not inconsistent with the provisions of the applicable Plan, with respect to any civil actions brought under the Program, a claimant

will be barred from bringing such civil action after one year from the date of exhausting the Program's claims procedures relating to the denial of such claim. In the case of a Group Health Plan claim discussed below, this includes not only exhausting the Program's internal claims procedure but also exhausting the Program's external claims procedure, where applicable.

Section 7.4 Special Rules for Group Health Plan Claims.

There are four categories of claims under a Plan that is a Group Health Plan and each one has a specific timetable for approval, request for additional information, or denial of the claim. The four categories of claims are:

Urgent Care Claim is a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition may determine if a claim is an Urgent Care claim.

Pre-Service Claim is a claim for which the claimant is required to get advance approval or pre-certification before obtaining service or treatment for a medical condition.

Post-Service Claim is a request for payment for covered services the claimant has already received.

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

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

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from the claimant will be sent within the timeframes shown in the chart below and will specify what information is needed. The claimant must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The determination period will be suspended on the date the Claim Fiduciary sends a notice of missing information and the determination period will resume on the date the claimant responds to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to

matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension that the claimant receives will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

Note that fully-insured Group Health Plan claims (if any) may be subject to even more accelerated response time for the insurers. See Certificates of Coverage for details.

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

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

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

- (i) The specific reason or reasons for the adverse determination;
- (ii) Reference to the specific Program provisions on which the determination was made;
- (iii) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- (iv) A description of the Program's review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action;

- (v) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
 - (vi) If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided free of charge upon request; and
 - (vii) If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Program Fiduciary will provide an independent full and fair review of the claimant's claim and will not give any deference or weight to the initial adverse determination. The claimant will receive a written notice of the decision on review.
- (c) How to Appeal a Denied Group Health Plan Claim. If a claim is denied, the claimant (or the claimant's attorney or other person authorized to act on the claimant's behalf) will have 180 days following the date the claimant receives written notice of the denial in which to appeal the claim. If the claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it under these procedures or in a court or any other venue. Unless the claimant is appealing the denial of an Urgent Care Claim, a request for review must be made in writing. If the claimant is requesting review of an Urgent Care Claim, the claimant may request review orally or by facsimile. A request for review should contain the claimant's name and address, the date the claimant received notice the claim was denied, and the reason(s) for disputing the denial. The claimant may submit written comments, documents, records, and other information relating to the claim. If requested, the claimant will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

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

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

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

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

The review will take into account all comments, documents, records, and other information submitted relating to a Participant's claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted by a Program Fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Program Fiduciary will provide an independent full and fair review of a Participant's claim and shall not give any deference or weight to the initial adverse determination. The Employee will receive a written notice of the decision on review. The notice will contain the following information:

- (i) The specific reason or reasons for the adverse determination;
- (ii) Specific references to the pertinent plan provisions on which the denial is based;
- (iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- (iv) A statement about the claimant's right to bring a civil action following any final adverse benefit determination;
- (v) A statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;
- (vi) A statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion

or limit, the Claim Fiduciary will, upon request, provide the claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances; and

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

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

- (d) Additional Internal Claims Provisions Requirements for Health Plans Under the ACA. Unless otherwise provided below, the following internal claims provisions relating to an "Adverse Benefit Determination" generally apply (subject to any grace period extensions by the Department of Labor ("DOL")) to Group Health Plans (other than ones offering only HIPAA-Excepted Coverage). For purposes of this Section 7.4(d), "Adverse Benefit Determination" means a claim denial (including a final internal adverse benefit determination) *neither involving a Grandfathered Plan nor HIPAA-Excepted Coverage* by the Contract Administrator or a Claim Fiduciary (as identified in Section 4.1 above) that involves any medical claim or any claim involving rescission of coverage. This determination may be appealed by the claimant and may be subject to external review under certain circumstances provided below.
 - (i) With respect to any rescission, such rescission shall be permissible only upon a finding of fraud or intentional misrepresentation of a material fact;
 - (ii) The claimant must be provided by the Program (free of charge) as soon as possible with any new or additional evidence considered, relied upon, or generated by the Program or Claim Fiduciary in connection with the claim as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale, both in the case of an initial determination or a final internal Adverse Benefit Determination;
 - (iii) To avoid conflicts of interest and to assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion or other similar matters involving an individual claims reviewer (such as a claim adjudicator

or a medical expert) must not be made based on the likelihood that such individual will support the denial of benefits;

- (iv) Notices to claimants by the Program or Claim Fiduciary must also include additional content as follows:
- a. Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon request by the claimant, the diagnosis code and treatment code and their corresponding meanings will be provided and, upon any such request by a claimant, any such code and meaning must be provided as soon as practicable.
 - b. Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Program's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.
 - c. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
 - d. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist the claimant.
 - e. Notices in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to a claimant in the health plan who reside in a county in which ten (10) percent or more of the population is

literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in such other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Program or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

- (v) Failure to adhere to all the requirements, described previously relating to the ACA, will allow the claimant to deem the internal claims and appeals process non-compliant (and exhausted), and the claimant may proceed to pursue any external review process or remedies (including court action). Notwithstanding the above, action or inaction relating to the above rules that is (i) de minimis, (ii) non-prejudicial to the claimant, (iii) attributable to good cause or matters beyond the Program's or Claim Fiduciary's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance, will not be considered non-compliant.

- (e) Additional External Claims Provisions Requirements for Health Plans Under the ACA. With respect to any Adverse Benefit Determination (defined in Section 7.4(d)) that involves medical judgment (including, but not limited to, a determination regarding medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time), an external review is to be provided to a claimant either under the State external appeals process or the Federal external appeals process as described in the following paragraphs of this section.

- (i) For "**State Review Plans**" (i.e., plans with insurance contracts approved by a state that has an external review

process that the DOL has determined includes acceptable minimal protections to claimants), the DOL provides that the state's external review process shall apply to the applicable fully-insured arrangement (and to certain self-funded arrangements that have been allowed by State law to be subject to the State's review rules). These safe harbor rules shall continue to apply to states meeting the "strict standards" but shall only apply to states meeting the "similar standards" until January 1, 2018, as more fully described below. (Please refer to the table identified here: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.)

- a. A state may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections based on the National Association of Insurance Commissioners ("NAIC")'s Uniform Health Carrier External Review Model Act (the "NAIC Model Act") in place on July 23, 2010.
- b. A State may operate an external review process under "similar standards" to those outlined in the NAIC Model Act subject to certain requirements by the DOL and other governmental authorities (These "similar standards" apply until January 1, 2018).
- c. *State Review Plans* are subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to claimants by the insurance company or the Program.

(ii) For "***Federal Review Plans***" (i.e., plans that are (i) self-funded or (ii) have not elected or are not eligible to be State Review Plans), the DOL provides that the following basic requirements apply under its safe harbor rules (which are based in significant part on the NAIC Model Act). The external review rules may be provided in more detail in an underlying document (which may also contain provisions for the Program's benefits) that is made part of the Program.

- a. A claimant shall have four months after the day you receive notice or are deemed

notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination;

- b. The Program or Claim Fiduciary shall have five business days from the date the claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether the claimant was covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully;
- c. Within one business day after the preliminary review, the Program or Claim Fiduciary shall notify in writing the claimant of its decision. If the claim is complete but not eligible for external review, the reason for its ineligibility and contact information for the Employee Benefits Security Administration must be provided to the claimant. If the claim is incomplete, an explanation of what is necessary to complete the claim must be requested of the claimant and the Program or Claim Fiduciary must permit the claimant a reasonable time to perfect the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompleteness);
- d. If the claimant appeals an appealable final internal adverse benefits determination (or challenges whether or not it is appealable), the claim must be referred (i) to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or (ii) by a similar nationally-recognized accrediting organization to conduct external reviews, on a random basis among two IROs in both cases contracted with by the Contract Administrator or Claim

Fiduciary (which may be done through global contracts obtained by a third party administrator) and which provide in such existing contract for a rotating or other unbiased (e.g., random) method of selection and without financial incentives tending toward denial of benefits. However, where these conditions are not strictly met, the DOL will make a determination on a case-by-case basis of the Program's compliance with the external claims review requirements of the ACA;

- e. Once assigned to the IRO, the IRO must make a determination on a *non-urgent care claim* within forty-five days after the IRO receives the assignment;
- f. If the IRO reverses the decision of the Program or Claim Fiduciary, payments or coverage must begin immediately, even if the Program or Claim Fiduciary expects to appeal it to a court of law;
- g. The claimant must have a right to expedited review for an Urgent Care claim. The standards for an Urgent Care claim under external review are the same as those under the internal review (e.g., upon request for expedited treatment by the claimant, delay would (i) seriously jeopardize the life or health of the claimant or (ii) jeopardize the claimant's ability to regain maximum function). Once assigned to the IRO, the IRO must make a determination on an Urgent Care as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request. If the IRO's notice of its determination is not provided in writing within 48 hours after the date of providing that notice it must provide written confirmation to the Employee and the Program; and
- h. The contracts with the IROs must include the requirements contained in DOL Technical Releases 2010-01 and 2011-02,

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

- (iii) Pursuant to DOL pronouncements, if the Program complies with either the State or Federal interim compliance methods described previously, no excise tax liability should be reported on IRS Form 8928 with respect to Section 2719(b) of the Public Health Service Act. Further, the DOL will not take enforcement action against a plan that has voluntarily complied with a State external review process (where available to a plan in the applicable state) that meets the strict standard or the similar standard of the NAIC Model Act described previously. The Program intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA, and the provisions herein should be interpreted accordingly.

Section 7.5 Disability Claims.

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

A disability claim is a claim that requires the Program to determine if the claimant is disabled for purposes of eligibility for disability benefits under a Plan. Except as provided in this Section 7.5, the general claims procedures in Section 7.3 apply, including but not limited to the provisions relating to any Program Fiduciary's rights and responsibilities as provided in Section 7.3(c) and the claims limitation period identified in Section 7.3(d).

- (a) Time for a Decision on a Disability Claim. The Program will notify the claimant of its determination within 45 days after its receipt of the claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Contract Administrator. If an extension of time is required, the claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If, prior to the end of the first 30-day extension period, the Claim Fiduciary determines that an additional extension is necessary due to

matters beyond its control, the Claim Fiduciary may take up to an additional 30 days to review the claim. If an additional extension of time is required, the claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension the claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The claimant has at least 45 days to provide the specified information.

- (b) Notification of Denial. The Program will notify the claimant of its initial claim determination in accordance with the procedures set forth in Section 7.4 (b).
- (c) How to Appeal a Denied Disability Claim. The claimant may appeal the Program's determination within 180 days following receipt of an adverse determination in accordance with the procedures set forth in Section 7.4(c). The Program will notify the claimant of its determination on review within 45 days. Under special circumstances, the Claim Fiduciary may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The claimant has at least 45 days to provide the specified information.
- (d) Notification of Benefit Determination on Review. The claimant will receive written notice of the Program's benefit determination on review which, in the case of an adverse benefit determination, contains the information provided in Section 7.4(c).

ARTICLE EIGHT: Adoption by Participating Districts

Section 8.1 Adoption Procedure.

Any Participating District may adopt the Program provided Schools Risk and Insurance Management Group approves the adoption of the Program by the Participating District. Any Participating District agrees to be bound by the terms of the Program and any other terms and conditions that may be required by Schools Risk and Insurance Management Group or its delegate, provided that such terms and conditions are not inconsistent with the purposes of the Program.

Section 8.2 Adoption Agreement.

If Schools Risk and Insurance Management Group should so require, the adoption of the Program by any Participating District may be made subject to a written Adoption Agreement.

Section 8.3 Employer Reimbursement.

Each Participating District shall, upon demand from Schools Risk and Insurance Management Group, reimburse Schools Risk and Insurance Management Group for the Participating District's appropriate share of any expenses, insurance premiums or funding necessary to provide benefits under the Program. The amount of such reimbursement shall be the sole discretion of Schools Risk and Insurance Management Group and binding on any adopting Participating District.

Section 8.4 Withdrawal as Participating Districts.

Any Participating District that adopts the Program may withdraw from the Program, but only with the express written approval, and within the sole discretion, of Schools Risk and Insurance Management Group, and such withdrawal shall constitute a termination of the Program as to such Participating District. Any such withdrawal and termination must be in writing and filed with Schools Risk and Insurance Management Group by December 31 in order to be effective for the following Program Year. Unless waived by Schools Risk and Insurance Management Group, an Participating District shall be responsible as to Participants and covered Dependents for any such person's claims incurred but not presented for payment as of the date of withdrawal.

Section 8.5 Contract Administrator's Right to Terminate Adoption.

Schools Risk and Insurance Management Group has the right to terminate any Participating District's adoption of or participation in the Program at any time.

ARTICLE NINE: Miscellaneous

Section 9.1 Governing Law.

This Program shall be construed, enforced, and administered in accordance with the laws of California, except to the extent that those laws are superseded by the Federal law of the United States of America, in which case such Federal law shall apply. If any provision of the Program or the application thereof to any circumstance or person is invalid, the remainder of the Program and the application of such provision to other circumstances or persons shall not be affected thereby.

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

- (a) Benefits for Adopted Children. Employer Group Health Plans will extend benefits to Dependent children who are adopted or placed with a

Participant for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants.

- (b) CHIP. The Children's Health Insurance Program ("CHIP") and Medicaid were expanded to include the special enrollment rights of Employees and Dependents beyond acquiring a Dependent by birth, marriage, or adoption or losing other medical coverage that was in place at the time of the original coverage. Employees and Dependents who are eligible but not enrolled in a health plan must also be given the opportunity to do so where (i) the Employee's or Dependent's Medicaid or CHIP coverage is terminated due to a loss of eligibility, or (ii) the Employee or Dependent becomes eligible for a subsidy under Medicaid or CHIP. An Employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario if enrollment is desired. Employees have the option to keep their children covered under the state's health program or enroll them in the employer's health plan.

To be "qualified employer-sponsored coverage" under the law, (i) the Group Health Plan or health insurance coverage must be creditable coverage for HIPAA purposes; (ii) the Employer contribution toward the cost of any premium for the coverage must be at least 40%; and (iii) the coverage must be available to individuals in a manner that would be considered to be a nondiscriminatory group for eligibility purposes under Section 105(h) of the Code. CHIP specifically excludes coverage under health care flexible spending accounts and high deductible health plans ("HDHP"s).

Each state in which an Employee resides will choose whether or not it will implement this optional subsidy. It will then decide whether the subsidy will be paid: (i) directly to Employees as a reimbursement of their portion of the Group Health Plan premium and other out-of-pocket expenditures; or (ii) directly to employers on behalf of the Employees. In this latter instance, an employer may opt-out of receiving the premium assistance subsidy so that the subsidy would be paid directly to the Employee. This opt-out will permit the employer to continue to withhold the Employee's full premium obligation and avoid direct involvement with the subsidy program.

The amount of premium assistance available is the incremental premium cost difference between coverage for the Employee only and coverage for the Employee plus the eligible child or children.

Employers must notify all Employees about the new CHIP special enrollment rights regardless of enrollment status. The enrollment notice may be given to Employees together with the Group Health Plan's eligibility and enrollment information, open enrollment packets, or summary plan description.

An Employer must also provide an annual notice to all Employees regarding the assistance available and how to apply for such assistance, regardless of enrollment status. Each Employer sponsoring a Group Health Plan must provide the Employer Medicaid/CHIP Notice to applicable Employees.

In addition, CHIP requires plan sponsors to provide disclosure information to state agencies regarding when a plan Participant or beneficiary is covered under the company's Group Health Plan and Medicaid or CHIP. This disclosure is designed to assist states in determining the cost-effectiveness of providing the premium assistance subsidies. The law directs the Department of Health and Human Services and the Department of Labor to develop a model disclosure form for this purpose. States may not request this information until the first plan year that begins after the date on which the model form is first issued.

- (c) Continuation Coverage Under COBRA. Where the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") applies to a Plan, such Plan shall be operated in accordance with such law. Generally, if the Group Health Plan coverage for a Participant or their eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of Dependent), then the Participant and their eligible family members may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. Consistent with law, the Contract Administrator (or third-party COBRA administrator, if any) will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after participation ends or from the date of receipt of the form, whichever is later. The Plan will offer COBRA continuation coverage only after the Contract Administrator (or third-party COBRA administrator, if any) has been notified that a qualifying event has occurred. COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. In the event any provision of this document, including the applicable Exhibits, fails to comply with the requirements of applicable law or fails to determine the rights or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by this Plan be greater than those required to be provided by COBRA.

To continue group health coverage under COBRA, the Employer may elect to charge the qualifying beneficiary up to 102% of the full cost of the coverage (or 150% in the case of an 11-month extension due to disability). These payments are to be made during the 18, 29 or 36-month period of continuation coverage according to the COBRA rules. The first premium

payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date.

As an additional benefit, the Contract Administrator may in its sole discretion extend to civil union partners, and qualified same-sex domestic partners the rights which may parallel the Federal laws of COBRA ("COBRA-like rights"). Where such extension has been made, the applicable Certificate of Coverage (or its equivalent) will address the details. Any COBRA-like rights offered under the Program to such persons presently do not enjoy the same income tax benefits at the Federal level as regular COBRA benefits and may not at the state level. This document does not address Federal, state and local tax treatment in detail, and is not intended to provide tax advice.

- (d) Family and Medical Leave Act Coverage. The Family and Medical Leave Act ("FMLA") of 1993 generally applies to public agencies. FMLA also requires an employee to have worked a certain number of hours and months in order to be eligible. Where applicable this law provides certain rights and options relating to Group Health Plan coverage. It requires covered public agencies to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. Such family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's Spouse, child, or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform their job.

In 2008 the FMLA was expanded regarding an eligible employee's parents or immediate family members being called to active military duty status or in active military duty: first, the events for triggering family leave now include "qualifying exigencies" of covered service members. Second, with respect to care for covered service members with a serious injury or illness, eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period.

While an employee is on FMLA leave, the public agency must maintain the employee's health coverage, including family coverage, under any Group Health Plan on the same terms as if the employee had continued to work. Any changes to the Group Health Plan during the time an employee is on FMLA leave apply to that Employee's health benefits. Notice of any opportunity to change plans or benefits must also be given to an employee on FMLA leave.

Covered public agencies must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any

additional information required as well as the employees' rights and responsibilities. If they are not eligible, the public agency must provide a reason for the ineligibility. Covered public agencies must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the public agency determines that the leave is not FMLA-protected, the public agency must notify the employee.

However, an employee may choose not to retain health coverage during FMLA leave. When the employee returns from FMLA leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave. Upon return from FMLA leave, most employees will be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms to the extent required by the law. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee's leave.

The public agency's obligation to maintain health benefits under FMLA stops if the employee's premium payment is more than 30 days late and the public agency has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received. If an employee's coverage lapses because he or she failed to make their premium payments, the public agency must restore the employee's coverage upon return from FMLA leave; the employee cannot be required to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

A public agency's obligation to maintain health benefits under FMLA also stops if and when an employee informs the public agency of intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave entitlement is exhausted for a reason other than medical necessity. Generally, if the employee does not return from leave, the public agency has the right to request reimbursement for any payments made for the employee's coverage during leave.

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

- (e) GINA. The Genetic Information Nondiscrimination Act ("GINA") applies to certain health plans (generally those that are not HIPAA-excepted). GINA states that health benefit plans may not discriminate on the basis of genetic information with respect to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by a "covered

entity” or “business associate” as defined under HIPAA. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

Where GINA applies, genetic information is treated as protected health information under HIPAA. Under GINA, the plan must provide that an employer cannot request or require that the individual reveal whether genetic testing has or has not occurred relating to that individual, nor can an employer require an individual to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums. Covered entities and business associates may not use genetic information for restricted underwriting purposes. “Restricted underwriting purposes” include underwriting activities involving eligibility determinations, premium computations, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

GINA allows an additional exception to the general prohibition described above. This exception applies where an employer offers an incentive (which, prior to January 1, 2019, was subject to certain limitations) for an employee’s spouse to provide information about the spouse’s current or past health status as part of a voluntary wellness program.

- (f) HIPAA Portability and Privacy Requirements. Where HIPAA applies to a Plan, such Plan shall be operated in accordance with such law. Where GINA applies, genetic information is treated as protected health information under HIPAA.

In addition, a Group Health Plan that is subject to HIPAA (i.e., not HIPAA-Excepted Coverage) must comply with the following:

- (i) If a Group Health Plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);
- (ii) For Program Years beginning on or after January 1, 2014, a Group Health Plan may not apply a “Preexisting Condition Exclusion” (as defined under HIPAA);
- (iii) A Group Health Plan must provide for special enrollment opportunities. These rules are explained in more detail in the Certificate of Coverage relating to the applicable Group Health Plan;
- (iv) Where a wellness program subject to HIPAA is offered under the Program, the Program will provide a reasonable alternative standard for participation in all Program

materials describing the program. This may include tailoring the standards for each individual on a case-by-case basis in order to comply with the HIPAA wellness rules; and

- (vi) Where extension of benefits has been made to civil union partners, and qualified same-sex domestic partners, the HIPAA privacy rights shall apply.
- (g) Mental Health Parity Act. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) generally requires that, where the employer employs more than 50 employees and its health plan provides for mental health and substance abuse benefits, parity is required between mental health/substance abuse benefits and medical/surgical benefits offered under a Group Health Plan. Therefore, financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars or scope or duration of treatment may not be substantially more limited than for medical/surgical benefits provided.

An exemption under MHPAEA exists in which a Group Health Plan sponsor is able to demonstrate that compliance with MHPAEA results in increased claims of at least 2% in the first year the plan is subject to MHPAEA or 1% in subsequent years. If a Group Health Plan obtains a certified actuarial report demonstrating the increase in actual costs, then the plan qualifies for exemption from the parity requirements for one year. Under MHPAEA, plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year. Thus, the increased cost exemption may only be claimed for alternating plan years.

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

- (h) Michelle’s Law. Michelle’s Law applies to Group Health Plans in limited circumstances. Michelle’s Law states that health benefit plans must provide extended coverage to a Participant’s Dependent, who as a full-time student in a postsecondary educational institution would otherwise lose coverage because of taking medically-necessary leave due to a serious illness or injury. This extension is required for up to twelve (12) months or, if earlier, the date the coverage would otherwise end under such Plan.

This extended coverage may be conditioned on the Program’s receipt of a certification from a physician who has examined the Dependent and

represents the need for the Dependent's leave or change in enrollment status due to the serious illness or injury. The Program must furnish information about Michelle's Law in any notice regarding a certification of student status required for continued coverage under the health plan component of the Program. Such notice must describe rights to continued coverage during a medically necessary leave of absence. The Program intends to be in good faith compliance with the law and, therefore, any language in the Program or a Plan to the contrary is to be superseded by the requirements of Michelle's Law.

- (i) Newborns' and Mothers' Health Protection Act. Group Health Plans and health insurance insurers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the previously discussed periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance insurer for prescribing a length of stay not in excess of such periods.
- (j) The Affordable Care Act. The ACA requires the modification of Group Health Plans in a number of ways. Below are significant changes (which may also be reflected in the applicable Certificates of Coverage) that affect Group Health Plans *that are neither a grandfathered plan nor HIPAA-Excepted Coverage*:
 - (i) If a Participant or Dependent receives emergency services in the emergency department of a hospital, such Participant or Dependent is not required to obtain prior authorization, and such Participant's or Dependent's cost-sharing obligations (including co-payments and co-insurance) will be the same as would be applied to care received by preferred providers; however, such Participant or Dependent may be responsible for the allowed amount under the Group Health Plan and the amount billed by a non-network provider, to the extent permitted by the ACA;
 - (ii) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women, provided, however, due to DOL interim final regulations

issued on August 27, 2014, closely-held for-profit employers and religious non-profit employers may, under certain circumstances, decline to provide insurance plans offering certain forms of contraception as part of their minimum preventive care services;

- (iii) If the Group Health Plan requires or allows a Participant to select a primary care physician (“PCP”), the Participant can designate any participating PCP (who participates in the network and who is accepting new patients) as the designated PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered Dependent child; if the Group Health Plan designates a PCP automatically, until a Participant makes this designation, the Group Health Plan or health insurer will designate one for the Participant;
- (iv) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals; and
- (v) Internal appeal and external review claim procedures are revised as provided in the Section 7.4 of this Program Document.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *both Grandfathered Plans and non-grandfathered Group Health Plans that are not HIPAA-Excepted Coverage*:

- (i) Any lifetime and annual maximum no longer applies to essential health benefits (to the extent covered under the Group Health Plan), which include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and

vision care (collectively, “Essential Health Benefits”). For purposes of determining whether a benefit or service is an essential health benefit relating to permissible annual or lifetime limits and cost sharing limits under the ACA, the Plan must choose a benchmark state;

- (ii) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days’ advance notice to an individual before coverage is rescinded;
 - (iii) If a health plan includes coverage for Dependents, a Participant’s child (including step-child, legally adopted child, a child placed for adoption and a child under a Qualified Medical Child Support Order or National Support Notice described in more detail in Section 9.1(k) below) is covered until the end of the calendar month in which such child turns age 26 regardless of such child’s tax dependent status;
 - (iv) Discrimination is prohibited against health care providers acting within the scope of their professional license and applicable state laws;
 - (v) It is prohibited for a health plan to drop coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial or deny coverage for routine care that would otherwise be provided because an individual is enrolled in a clinical trial; and
 - (vi) The annual limitation (for other than HSA-compatible high-deductible health plans, which limits are less) on the out-of-pocket maximum on essential health benefits, for plan years beginning in 2019, is \$7,900 for self-only coverage and \$15,800 for coverage other than self-only coverage (increased in both cases in future years by the premium adjustment percentage described under ACA Section 1302(c)(4)).
- (k) Qualified Medical Child Support Orders. The Employer’s group health, vision and dental plans will provide benefits as required by any Qualified Medical Child Support Order (“QMCSO”) and will provide benefits to Dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants. The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants’ Spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

- (l) Uniformed Services Employment and Reemployment Rights Act Coverage. Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), shall continue to participate and be eligible to receive benefits under the Program in accordance with USERRA rules and regulations.
- (m) Women’s Health and Cancer Rights Act. The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage for (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to provide symmetrical appearance; and (iii) prostheses and treatment of physical complications during all stages of the mastectomy, including lymphedema.

Section 9.2 Communication to Employees.

The Employer will notify all Employees of the availability and terms of the Program at such time and in such manner as the Contract Administrator may determine.

Section 9.3 Limitation of Rights.

Neither the establishment of the Program nor any Program amendment will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, Schools Risk and Insurance Management Group, or any Participating District, except as expressly provided in this Program document or under applicable law, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

Section 9.4 Benefits Solely from General Assets.

The Contract Administrator intends that in most instances the benefits provided under this Program will be paid solely from the general assets of Schools Risk and Insurance Management Group or through insurance. Where benefits are provided by insurance, Schools Risk and Insurance Management Group has no obligation for the payment of such benefits, except as expressly provided by the Program.

Section 9.5 Mistaken Contributions.

If any contribution is made by the Employer because of a mistake of fact, the portion of that contribution due to the mistake of fact shall be returned to the contributor as permitted by the Code.

Section 9.6 Non-Alienation of Benefits.

No benefit, right or interest of any Participant or beneficiary under the Program shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Section 9.7 Nondiscrimination Requirements.

All rules, decisions, interpretations and designations by the Plan Administrator under the Program shall be made in a nondiscriminatory manner, and persons similarly situated

shall be treated alike. Further, this Program shall not in operation discriminate in favor of “highly compensated individuals” (as defined under Code Section 414(q)) as to eligibility to participate or in favor of “highly compensated individuals” as to contributions and benefits as required by any applicable provisions of the Code, including, but not limited to, Sections 79 and 105(h) and 125. If the Plan Administrator determines during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirement imposed on the Plan by the Code or may exceed any limitation on benefits provided to “highly compensated individuals,” “key employees” or such other Employees or classification of Employees for whom benefits may not be discriminatory under the Code, the Plan Administrator shall have the discretion and authority to take such action as it deems necessary to assure compliance with such nondiscrimination requirement limitation.

Section 9.8 Union Agreements. Notwithstanding anything to the contrary in this document, this Program is subject to collective bargaining agreement(s) with the following union(s): Auburn Union School District (Certificated & Classified), 255 Epperle Lane, Auburn, CA 95603; CTA, 950 Tharp Road, Suite 901, Yuba City, CA 95993; Clear Creek Certificated Bargaining Unit, 17700 McCourtney Road, Grass Valley, CA 95945; Association of Colfax Educators (ACE), Certificated Teacher, 24825 Ben Taylor Road, Colfax, CA 95713; CTA Membership Accounting, P.O. Box 4178, Burlingame, CA 94011-4178; California School Employees Association, 2045 Lundy Avenue, San Jose, CA 95131; California Teachers Association, P.O. Box 921, Burlingame, CA 94011-0921; California Teachers Association (CTA), P.O. Box 45529, San Francisco, CA 94145-0529; Amalgamated Transit Union, Local 256, 2776 21st Avenue, Sacramento, CA 95841; EUTA - Eureka Union Teacher's Association (CTA/NEA), P.O. Box 4178, Burlingame, CA 94011-4178; EUCO - Eureka Union Classified Organization, 5455 Eureka Road, Granite Bay, CA 95746; California School Employees Association (CSEA), 8217 Auburn Boulevard, Citrus Heights, CA 95610-0310; Nevada Joint Union High School Teachers Association, 11645 Ridge Road, Grass Valley, CA 9595; California School Employees Association, Chapter 165, 11645 Ridge Road, Grass Valley, CA 95945; Placer/Nevada Teachers Union AFT, Local 2267, AFL-CIO, 11645 Ridge Road, Grass Valley, CA 95945; CTA, 8951 Valley View Drive, Newcastle, CA 95658; CSEA, 8951 Valley View Drive, Newcastle, CA 95658; PACE/CTA, 41 Truxel Road, Sacramento, CA 95834; Certificated Union, P.O. Box 255, Weimar, CA 95736; Classified Union, 16505 Placer Hills Road, Meadow Vista, CA 95722; CSEA, P.O. Box 1764, Colfax, CA 95713; Roseville Secondary Association (RSEA), 1750 Cirby Way, Roseville, CA 95661; Union Hill Teacher Association (UHTA), 11638 Colfax Highway, Grass Valley, CA 95945; CTA/WPTA Certificated, P.O. Box 921, Burlingame, CA 94011 (the “Union Agreement”). The Union Agreement requires, among other things, certain benefits be provided to the applicable union members and that they are subject to the applicable Union Agreement. Therefore, the Program, including any benefits provided for hereunder and any changes to the Program or to a Plan to the extent subject to the applicable Union Agreement, is to be interpreted in such a fashion as to be in harmony with the applicable Union Agreement.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing, Schools Risk and Insurance Management Group has caused the Program to be duly executed in its name and on its behalf, to be effective as of July 1, 2020.

Schools Risk and Insurance
Management Group

By: _____

Title: _____

Date: _____

DRAFT

EXHIBIT A: PLANS

Schools Risk and Insurance Management Group Health and Welfare Program

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

Plans Offered Under the Program

Attached is a list of each Plan and the eligibility and participation requirements of those plans. Also listed may be the name of the Insurance Company or Administrator that processes claims.

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

EXHIBIT B: LOOK-BACK PROVISIONS

Schools Risk and Insurance Management Group Health and Welfare Program

PART ONE: Definitions to Look-Back Provisions

Where the following words and phrases appear in the Exhibit, they shall have the respective meanings set out below, unless their context clearly indicates otherwise.

- (a) **Applicable Large Employer** means, with respect to a calendar year, an Employer that employed an average of at least 50 **Full-Time Employees** (including full-time equivalent Employees) on business days during the preceding calendar year. In making the **Applicable Large Employer** determination, all persons treated as a single Employer under Code Section 414 (b), (c), (m) or (o) are treated as one Employer.
- (b) **Continuing Employee** means an Employee whose break in service was shorter than one resulting in treatment as a **New Employee** under the Rehire Rules.
- (c) **Dependent** means as to Look-Back Provisions, unless otherwise specifically provided in a Plan (to the extent such provisions are in compliance with Federal law), a natural or adopted child and a child for whom the Employee and/or the Employee's Spouse are the legal guardian or for whom the Employee or Employee's Spouse has legal custody or any other person specified as such in **Exhibit A** as to Look-Back Provisions.
- (d) **Employment Break Period** means a period of at least four consecutive weeks (disregarding **Special Unpaid Leave**), measured in weeks, during which an Employee is not credited with **Hours of Service**. This applies only to educational organizations using the look-back measurement method.
- (e) **Full-Time Employee** means, with respect to a calendar month, an Employee who is employed an average of at least 30 **Hours of Service** per week with an Employer.
- (f) **Hours of Service**
 - (i) *In general.* The term **Hour of Service** means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity

(including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)). For the rules for determining an Employee's hours of service, see Code Reg. Section 54.4980H-3 (generally, Employers calculate **Hours of Service** for Employees paid on an hourly basis from records of hours worked and hours for which payment is made or due). Employees paid on a non-hourly basis (such as salaried Employees) may have their **Hours of Service** calculated using the same method as for hourly Employees or may choose a "days-worked" or a "weeks-worked" equivalency so long as such an approach would not result in a substantial understatement of a non-hourly Employee's **Hours of Service**.)

(ii) *Excluded hours*

(A) *Bona fide volunteers.* The term **Hour of Service** does not include any hour for services performed as a bona fide volunteer.

(B) *Work-study program.* The term **Hour of Service** does not include any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a substantially similar program of a State or political subdivision thereof.

(C) *Services outside the United States.* The term **Hour of Service** does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States (within the meaning of Sections 861 through 863 and the regulations thereunder).

(iii) *Service for other **Applicable Large Employer** members.* In determining **Hours of Service** and status as a **Full-Time Employee** for all purposes under Section 4980H, an **Hour of Service** for one **Applicable Large Employer** member is treated as an **Hour of Service** for all other **Applicable Large Employer** members for all periods during which the **Applicable Large Employer** members are part of the same group of Employers forming an **Applicable Large Employer**.

(g) **Initial Administrative Period** means an optional period, selected by an **Applicable Large Employer** member, of no longer than 90 days beginning immediately following the end of an **Initial Measurement Period** and ending immediately before the start of the associated **Initial Stability Period**. The **Initial Administrative Period** also includes the period between a **New Employee's** start date and the beginning of the **Initial**

Measurement Period, if the **Initial Measurement Period** does not begin on the Employee's start date. The **Initial Measurement Period** and **Initial Administrative Period** together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the Employee's start date.

- (h) **Initial Measurement Period** means a period selected by an **Applicable Large Employer** of at least three consecutive months but not more than 12 consecutive months used by the **Applicable Large Employer** as part of the look-back measurement method in § 54.4980H-3(d).
- (i) **Initial Stability Period** means a period selected by an **Applicable Large Employer** member that immediately follows, and is associated with, an **Initial Measurement Period** (and, if elected by the Employer, the **Initial Administrative Period** associated with that **Initial Measurement Period**), and is used by the **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H-3(d).
- (j) **Look-Back Measurement Method** means that an **Applicable Large Employer** determines each **New Employee's** or **Ongoing Employee's Full-Time Employee** status by looking back at the **Initial** or **Standard Measurement Period**.
- (k) **Monthly Measurement Method** means that an **Applicable Large Employer** determines each Employee's status as a **Full-Time Employee** by counting the Employee's **Hours of Service** for each calendar month.
- (l) **New Employee** means an Employee who has been employed by an **Applicable Large Employer** for less than one complete **Standard Measurement Period**.
- (m) **Ongoing Employee** means an Employee who has been employed by an **Applicable Large Employer** member for at least one complete **Standard Measurement Period**.
- (n) **Seasonal Employee** means an Employee who is hired into a position for which the customary annual employment is six months or less.
- (o) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act of 1993 (FMLA), 103, 29 U.S.C. 2601 et seq., or to the

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), 103, 38 U.S.C. 4301 et seq., or on account of jury duty.

- (p) **Standard Administrative Period** means an optional period, selected by an **Applicable Large Employer** member, of no longer than 90 days beginning immediately following the end of a **Standard Measurement Period** and ending immediately before the start of the associated **Standard Stability Period**.
- (q) **Standard Measurement Period** means a period of at least three but not more than 12 consecutive months that is used by an **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H-3(d).
- (r) **Standard Stability Period** means a period selected by an **Applicable Large Employer** member that immediately follows, and is associated with, a **Standard Measurement Period** (and, if elected by the Employer, the **Standard Administrative Period** associated with that **Standard Measurement Period**), and is used by the **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H-3(d).
- (s) **Variable Hour Employee**
- (i) In general, means an Employee if, based on the facts and circumstances at the Employee's start date, the **Applicable Large Employer** member cannot determine whether the Employee is reasonably expected to be employed on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** because the Employee's hours are variable or otherwise uncertain.
 - (ii) Factors
 - (A) In general. Factors to consider in determining whether the Employee is reasonably expected to be (or reasonably expected not to be) employed on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** include, but are not limited to, whether the Employee is replacing an Employee who was a **Full-Time Employee** or a **Variable Hour Employee**, the extent to which the **Hours of Service** of Employees in the same or comparable positions have actually varied above and below an average of 30 **Hours of Service** per week during recent measurement periods, and whether the job was advertised, or otherwise communicated to the **New Employee** or otherwise documented (for example, through a

contract or job description) as requiring **Hours of Service** that would average at least 30 **Hours of Service** per week, less than 30 **Hours of Service** per week, or may vary above and below an average of 30 **Hours of Service** per week. These factors are only relevant for a particular **New Employee** if the Employer has no reason to anticipate that the facts and circumstances related to that **New Employee** will be different. In all cases, no single factor is determinative. For purposes of determining whether an Employee is a **Variable Hour Employee**, the **Applicable Large Employer** member may not take into account the likelihood that the Employee may terminate employment with the **Applicable Large Employer** (including any member of the **Applicable Large Employer**) before the end of the **Initial Measurement Period**.

(B) Additional factors for an Employee hired by an Employer for temporary placement at an unrelated entity. In the case of an individual who, under all the facts and circumstances, is the Employee of an entity (referred to solely for purposes of this paragraph as a “temporary staffing firm”) that hired such individual for temporary placement at an unrelated entity that is not the common law Employer, additional factors to consider in determining whether the Employee is reasonably expected to be (or reasonably expected not to be) employed by the temporary staffing firm on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** include, but are not limited to, whether other Employees in the same position of employment with the temporary staffing firm, as part of their continuing employment, retain the right to reject temporary placements that the temporary staffing firm offers the Employee; typically have periods during which no offer of temporary placement is made; typically are offered temporary placements for differing periods of time; and typically are offered temporary placements that do not extend beyond 13 weeks.

(C) Educational organizations. An Employer that is an educational organization cannot take into account the potential for, or likelihood of, an **Employment Break Period** in determining its expectation of future **Hours of Service**.

(iii) Application only for look-back measurement method. The term **Variable Hour Employee** is used as a category of employees under

the **Look-Back Measurement Method** and is not relevant to the **Monthly Measurement Method**.

DRAFT

PART TWO: Look-Back Provisions

Notwithstanding anything herein to the contrary, for any Plan that is a health plan maintained by an **Applicable Large Employer** subject to the ACA's assessable penalty payments under Section 4980H of the Internal Revenue Code, the following rules apply in determining eligibility for and coverage of **New Employees** and **Ongoing Employees**, as well as their **Dependents**:

- **New Employees** will have their **Hours of Service** counted during an **Initial Measurement Period** of 12 months to determine whether they have worked an average of at least 30 hours per week (“the 30-Hour Weekly Average”) if, based on the facts and circumstances at Employee’s start date, an Employer cannot determine whether Employee is reasonably expected to be employed for the 30-Hour Weekly Average (such as **Variable Hour Employees**, **Seasonal Employees**, and employees of educational organizations). If Employee is found to have met the 30-Hour Weekly Average, Employee will then be offered health coverage for an **Initial Stability Period** of 12 months.
 - The 12-month **Initial Measurement Period** will begin on the first of the month coinciding with or following the date of hire.
 - The one (1) month minus one (1) day **Initial Administrative Period** will immediately follow the **Initial Measurement Period**.
 - The 12-month **Initial Stability Period** will begin immediately following the **Initial Administrative Period**.
- **New Employees** reasonably expected to be **Full-Time Employees** at their start date will have their **Hours of Service** counted using the **Monthly Measurement Method** from their date of hire until they have completed one full **Standard Measurement Period** and become **Ongoing Employees**. Once they have completed one **Standard Measurement Period** and become **Ongoing Employees**, they will be measured using the **Look-Back Measurement Method**.
 - **New Employees** reasonably expected to be **Full-Time Employees** at their start date must be offered coverage by the first day of the month immediately following the conclusion of the Employee’s initial three full calendar months of employment.
- **Ongoing Employees** will have their **Hours of Service** counted during a **Standard Measurement Period** of 12 months to determine whether they have worked the 30-Hour Weekly Average. If Employee is found to have met the 30-Hour Weekly Average, Employee will then be offered health coverage for a **Standard Stability Period** of 12 months.

- The 12-month **Standard Measurement Period** will begin on May 1, 2019 and end on April 30, 2020, and will begin on May 1 and end on April 30 of each succeeding year thereafter.
 - The two (2) month **Standard Administrative Period** will begin on May 1, 2020 and end on June 30, 2020, and will begin on May 1 and end on June 30 of each succeeding year thereafter.
 - The 12-month **Standard Stability Period** will begin on July 1, 2020 and end on June 30, 2021, and will begin on July 1 and end on June 30 of each succeeding year thereafter.
- **Transition from a New Employee to an Ongoing Employee:** A **New Employee** must be measured for the first **Standard Measurement Period** for which Employee is employed. This means that a **New Employee** may have **Hours of Service** counted during the **Initial Measurement Period** and, at the same time, may have **Hours of Service** counted during an overlapping **Standard Measurement Period**. A **New Employee** becomes an **Ongoing Employee** if Employee remains employed for an entire **Standard Measurement Period**.
 - **New Employee (Variable Hour, Seasonal, etc.) Change in Employment Status:** For a **New Employee** who experiences a “change in employment status” during their **Initial Measurement Period** such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be full-time, an Employer is not subject to an assessable payment for that employee until (i) the first day of the fourth full calendar month following the change in employment status, or (ii) if earlier and the employee is a **Full-Time Employee** based on the **Initial Measurement Period**, the first day of the first month following the end of the **Initial Measurement Period** (including any **Initial Administrative Period**).
 - **Ongoing Employee Change in Employment Status:** An **Ongoing Employee** who experiences a “change in employment status” before the end of the **Standard Stability Period** will not have any change in classification as a **Full-Time** or non **Full-Time Employee** for the remaining portion of the stability period; however, the Employer may choose to make use of the special rule, as permitted by the ACA. Under this rule, if an Employee experiences a “change in employment status” to a position where the Employee will be working consistently under 30 hours per week, and the Employee was offered minimum value from the first day of the calendar month following three months of employment through the “change in employment status,” the Employer may follow the steps below to determine continued eligibility for health coverage:

- For first three months following the “change in employment status,” Employee remains covered under the **Standard Stability Period**;
 - On the first of the fourth calendar month, the Employer may use the **Monthly Measurement Method** to determine eligibility;
 - The **Monthly Measurement Method** may be used until the end of the first full **Standard Measurement Period** and **Standard Administrative Period**; and
 - After that, the **Look-Back Measurement Method** must be used to determine eligibility.
- **Rehire Rules:** An employee who resumes providing service to an **Applicable Large Employer** after a period during which the employee was not credited with any **Hours of Service** may be treated as having terminated employment and been rehired as a **New Employee** only if the following conditions apply: (i) such employee had no **Hours of Service** for a period of at least 13 consecutive weeks (26 for educational organization Employers); and (ii) such employee had a break in service of a shorter period of at least four consecutive weeks with no credited **Hours of Service**, and that period exceeded the number of weeks of the employee’s period of employment.
 - **Break-in-Service Rules for Continuing Employees:** For purposes of applying the look-back measurement method to a returning Employee not treated as a **New Employee**, the Employer would determine the Employee’s average **Hours of Service** for a measurement period by computing the average after excluding any **Special Unpaid Leave** (and in the case of an educational organization, also excluding any **Employment Break Period**) during that measurement period and by using that average as the average for the entire measurement period. Alternatively, the Employer could treat the Employee as credited with **Hours of Service** for any periods of **Special Unpaid Leave** (and, in the case of an educational organization, any **Employment Break Period**) during that measurement period at a rate equal to the average weekly rate at which the Employee was credited with **Hours of Service** during the weeks in the measurement period that are not part of a period of **Special Unpaid Leave** (or, in the case of an educational organization, an **Employment Break Period**). In no case, however, as it relates to educational organizations, would the Employer be required to exclude (or credit) more than 501 **Hours of Service** during **Employment Break Periods** in a calendar year (however no such limit applies for **Special Unpaid Leave**).

- **Treatment of Continuing Employees:** Under the look-back measurement method, an Employee treated as a **Continuing Employee** retains, upon resumption of services, the status that the Employee had with respect to the application of any stability period. For example, if the **Continuing Employee** returns during a stability period in which the Employee had previously been treated as a **Full-Time Employee**, the Employee remains full-time upon return and through the end of the applicable stability period. A **Continuing Employee** treated as a **Full-Time Employee** will have been offered coverage upon resumption of services if such coverage is offered as of the first day that the Employee is credited with an **Hour of Service**, or, if later, as soon as administratively practicable (no later than the first day of the calendar month following resumption of services).
- **COBRA:** A qualifying event for purposes of reduction in hours of employment will be based off the loss of coverage date, assuming the loss of coverage occurs within 18 months of the reduction in hours.

These provisions are intended to comply with the look-back safe harbor options permitted under governmental regulations relating to the ACA and are not intended to expand rights relating to coverage or benefits of employees for any other purpose and should be so construed. As such, the primary purpose of these provisions is to avoid the penalties under Section 4980H of the Internal Revenue Code. For this purpose, no employee who would be otherwise excluded from the Plan shall be included under these provisions except to avoid such penalties.

EXHIBIT C: PARTICIPATING DISTRICTS ADOPTING PROGRAM

Schools Risk and Insurance Management Group Health and Welfare Program

The information in this Exhibit is effective July 1, 2020.

Participating Districts Adopting Program

Ackermann Elementary School District

Auburn Union School District

Chicago Park School District

Clear Creek Elementary School District

Colfax Elementary School District

Dry Creek Joint Elementary School District

Eureka Union School District

Foresthill Union School District

Loomis Union School District

Mid Placer Public Schools

Nevada City School District

Nevada County Superintendent of Schools

Newcastle Elementary School District

Placer Academy

Placer County Office of Education

Placer Hills Union School District

Placer Union High School District

Pleasant Ridge Union School District

Rocklin Unified School District

Roseville City School District

Roseville Joint Union High School District

Twin Ridges Elementary School District

Twin Ridges Charter School District

Union Hill School District

Western Placer Unified School District

Harvest Ridge Cooperative Charter School

Alta Dutch Flat Elementary School District