MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

WRAP PLAN DOCUMENT

Effective July 01, 2019

V03052018

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Mammoth-San Manuel Unified School District (the "Employer") hereby adopts the Mammoth-San Manuel Unified School District Welfare Benefit Plan (the 'Plan'), effective as of July 01, 2019.

ARTICLE I

Purpose

The purpose of the Plan is to provide to Participants, and their Spouses, Dependents, and Beneficiaries certain welfare benefits described herein. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA and the Code as amended, together with rulings and regulations promulgated thereunder.

ARTICLE II

Definitions

2.1 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

2.2 "Beneficiary" means a beneficiary as defined under a Welfare Program.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.4 "Dependent" means dependent as defined under a Welfare Program. However, for purposes of any group health plan listed in Appendix A that provides medical benefits (other than a retiree medical plan) and other Welfare Programs that provide medical benefits, a Dependent shall include a Participant's eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator) and, for Grandfathered Plans, prior to Plan Years beginning before January 1, 2014, who are not eligible to enroll in another employer's medical plan, other than the medical plan of a parent.

2.5 "Effective Date" means July 01, 2019.

2.6 "Employee" means any person providing services to the Employer or a Participating Employer as a common-law employee. To the extent permitted by law, independent contractors (even if re-characterized by the Internal Revenue Service as employees), leased employees within the meaning of Section 414(n) of the Code, and individuals designated by the Employer or Participating Employer as temporary employees shall not be Employees for purposes of this Plan. For purposes of any group health plan incorporated herein, the term

Employee shall include any variable hour, temporary or seasonal employees defined as a full-time employee under the ACA.

2.7 "Employer" means Mammoth-San Manuel Unified School District, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

2.8 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.9 "Former Employee" means any person formerly employed as an Employee.

2.10 "Grandfathered Plan" means the term as it is defined in the Department of Labor Regulations, 29 C.F.R. § 2590.715-1251.

2.11 "Leave of Absence" means a personal leave, medical leave or military leave, as approved by the Employer.

2.12 "Participant" means any Employee or Former Employee who satisfies the requirements of Article III of the Plan, has chosen to participate in the Plan and whose participation has not terminated in accordance with Section 3.3.

2.13 "Participant Contribution" means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-insured arrangement of the Employer as well as contributions used to purchase insurance contracts or policies.

2.14 "Participating Employer" means any member of the following group including the Employer, if such member adopts the Plan with the Employer's authorization as provided in Section 10.1: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix B. The Employer shall amend Appendix B as needed, to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix B may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.15 "Plan" means the Mammoth-San Manuel Unified School District Welfare Benefit Plan, as set forth herein and each Welfare Program incorporated hereunder by reference, as amended from time to time.

2.16 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.17 "Plan Year" means the twelve consecutive month period ending on June 30.

2.18 "Spouse" means a spouse as defined under a Welfare Program. Notwithstanding anything to the contrary contained herein, the term "Spouse" shall include a same-sex spouse who is legally married under applicable law.

2.19 "Welfare Program" means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit, including those that would be treated as an "employee welfare benefit plan" under Section 3(l) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and a part of the Plan. The documents for each Welfare Program are incorporated into this document. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer's Board of Directors.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan, including the written terms and provisions of any Welfare Program document, so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Welfare Program.

ARTICLE III

Eligibility and Participation

3.1 Eligibility. (a) An Employee shall be eligible to participate in the Plan only as specified in a particular Welfare Program listed in Appendix A. An eligible Employee does not include any individual who is in a division, department, unit, or job classification designated by the Employer as not benefit-eligible, regardless of the Employee's work schedule or number of hours worked, unless the Employee is included in the employer shared responsibility penalty calculations, as defined under the ACA, and the Plan Administrator elects to include such Employees as Eligible Employees. The Welfare Program may also designate those Spouses, Dependents, or Beneficiaries, if any, eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder.

(b) If the Employer has the equivalent of 50 or more full-time Employees, to the extent required by the ACA and other applicable federal law, an Employee shall be eligible to participate in the Employer's group health plan if, in addition to meeting other applicable criteria, the Employee is a full-time Employee who is employed an average of at least 30 hours of service per week with the Employer.

Full-time Employee status for group health plan coverage purposes will be determined in accordance with the measurement rules as specified by the federal government and as adopted by the Employer for all Employees (including variable hour, temporary and seasonal employees, if such classes exist within the Employer). Full-time Employee status does not include any temporary employee who is eligible for group health plan coverage through a leasing organization, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the Employer Shared Responsibility provisions of the ACA.

3.2 Enrollment. The Plan Administrator shall establish procedures in accordance with the Welfare Programs for the enrollment of eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.3 Termination of Participation. A Participant shall cease being a Participant in the Plan and coverage under this Plan for the Participant, his or her Spouse, Dependents and Beneficiaries, if any, shall terminate in accordance with the provisions of the Welfare Programs and the ACA.

ARTICLE IV

Funding and Benefits

4.1 Funding. (a) Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer or Participating Employer contributions shall be conditioned on a Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time ("Participant Contribution"). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer, Participating Employer or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant, Spouse, Dependent, or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Spouse, Dependent, or Beneficiary shall have any right to, or interest in, the assets of the Employer or Participating Employer.

(b) The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase insurance with respect to any Welfare Program, any benefits to be provided under such Welfare Program shall be the sole responsibility of the insurer, and the Employer or Participating Employer shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer). Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contributions shall be remitted to the appropriate insurer, as soon as practicable but not later than 90 days after such contributions are made and would otherwise have been paid to Participants in cash.

4.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

ARTICLE V

Plan Administration and Fiduciary Duties

5.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

5.2 Plan Administration. Except as otherwise provided in a Welfare Program:

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(x) To determine and announce any Participant Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

(xii) To take such action as may be necessary to cause any required payroll deduction of any Participant Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

(d) The Plan Administrator shall have sole discretion and authority regarding the distribution, or other use, of dividends, demutualization and/or the Medical Loss Ratio rebates, if any, from group health insurers.

5.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

5.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer and each Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the

Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE VI

Claims and Subrogation

6.1 Claims Procedure. Except as provided in Sections 6.2, 6.3 and 6.4, a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program.

6.2 Claims Procedures for Group Health Plans. (a) This Section is intended to comply with Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 29 C.F.R. § 2560.503-1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, provided such other claims procedure complies with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719. In accordance with those regulations, all claims and appeals for group health plan benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Notwithstanding any provision of this Article VI, a group health plan that is a Grandfathered Plan is not subject to the claims and appeals procedures under Department of Labor Regulation § 2590.715-2719.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator. For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for group health plan benefits under the Plan.

(c) Benefit Determinations. All adverse benefit determinations referenced below shall be written in a culturally and linguistically appropriate manner, and shall include the information required by Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(i) Post-Service Claims. A post-service claim is any claim that is filed for payment of benefits after health care has been received.

(A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan's benefit determination within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan Administrator's control and notifies the claimant before the end of the initial 15-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. The Plan Administrator shall, within 5 days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(iii) Urgent Care Claims. An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant's life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the claimant's health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination in writing or electronically as soon as possible, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations) after the Plan Administrator receives all necessary information, taking into account the severity of the claimant's condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If the claimant files an urgent care claim improperly, the Plan Administrator, within 24 hours after the claim is received, shall notify the claimant of the improper filing and how to correct it. The claimant shall have 48 hours (or such other time as prescribed in Department of Labor Regulations) to provide the requested information and shall be notified of a determination no later than 48 hours after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments, that is an urgent care claim as defined in paragraph (iii), shall be decided as soon as possible, and the Plan Administrator shall

notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant's request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with paragraph (iii).

(B) If an on-going course of treatment was previously approved for a specified period of time or number of treatments, and the claimant's request to extend treatment is non-urgent, the claimant's request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 29 C.F.R. § 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) The claimant shall be notified of the Plan Administrator's decision upon review as appropriate, in accordance with the content and timing requirements of Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to

submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

(i) Pre-Service Claim Appeal. The Plan Administrator shall have 15 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, to notify the claimant electronically or in writing of the appeal determination.

(ii) Post-Service Claim Appeal. The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, to notify the claimant electronically or in writing of the appeal determination.

(iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible, taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. Oral communications shall be followed up in writing.

(iv) The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals. Except as otherwise required by applicable law, if a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 29 C.F.R. § 2590.715-2719.

6.3 Claims Procedure for Benefits Based on Determination of Disability. (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation 29 C.F.R. § 2560.503-1. In accordance with that regulation, all claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

(b) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant's Beneficiary shall receive written notification of the "adverse benefit determination" as defined in 29 C.F.R. § 2560.503-1 in a culturally and

linguistically appropriate manner. A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, that regulation requires denial notices for disability claims to include:

(i) a discussion of the decision, including, if applicable, the basis for disagreeing with or not following the views of health care and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, or with a disability benefit determination regarding the claimant made by the Social Security Administration;

(ii) the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(iii) if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) 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 claimant's claim for benefits.

Claimants will receive adverse benefit determinations within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the claimant's entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

(c) The claimant shall have 180 days to appeal an adverse benefit determination. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making

the benefit determination before the Plan issues an adverse benefit determination on appeal. The claimant shall be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives the claimant's appeal request. The Plan's adverse benefit determination on review shall include the information required by Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, this adverse benefit determination must include a statement of the claimant's right to bring a lawsuit in federal court and a description of any applicable contractual limitations period that applies to the claimant's right to bring a lawsuit and its expiration date.

The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time and provided that the claimant is notified of the extension prior to the expiration of the initial 45-day period. Such notice shall state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

(d) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

(a) If the Welfare Program does not describe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or the Plan Administrator determines that the procedures described in Sections 6.2 or 6.3 with respect to a particular Welfare Program shall not apply, the claims procedure described in this Section shall apply with respect to such Welfare Program if the Welfare Program is subject to ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program shall supersede this procedure.

(b) If a Participant or former Participant asserts a right to any benefit under the Plan that the Participant has not received, the Participant or his or her authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written or electronic notice to the claimant within a reasonable period of time, but not later than 90 days after receipt by the Plan Administrator of the claim, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant:

(i) the specific reasons for the denial of the claim;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(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) an explanation of the Plan's claims review procedure, including the time limits applicable under such procedure; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:

(i) shall be provided a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination;

(ii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim; and

(iii) may submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

(d) Subject to Department of Labor Regulation 29 C.F.R. § 2560.503-1(i)(1)(ii), a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after receipt of the request for review.

(e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant's appeal which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator's decision shall include:

(i) the specific reasons for the adverse benefit determination;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination 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;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to receive information about any such procedures; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent or Beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(i) Award. "Award" means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual's Illness, Injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(ii) Covered Individual. "Covered Individual" includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.

(iii) Injury or Illness. "Injury" or "Illness" means such term as defined in each Welfare Program.

(iv) Reimbursement. "Reimbursement" means the Plan's right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the Illness, Injury or other loss that resulted in the payment of such benefits by the Plan.

(v) Subrogation. "Subrogation" means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual's lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual's Injury, Illness or other loss that resulted in a payment of benefits by the Plan.

(vi) Third Party. "Third Party" includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury or other loss, the Plan shall have the following rights:

(i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;

(ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) above from any Award arising out of such Injury, Illness or other loss; and

(iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual's immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) and a right to Reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan's subrogation/reimbursement/benefit offset rights (herein referred to collectively as "Recovery Rights") shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any Award paid to or for the benefit of the Covered Individual. The Plan does not recognize the "make whole" rule and a Covered Individual may not be whole after the Plan's Recovery Rights are satisfied.

(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any Award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an Award is paid to or for the benefit of the Covered Individual by a Third Party

with respect to such Illness, Injury or loss. The terms and provisions of such reimbursement/subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

By accepting an advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

(i) the Plan has a priority lien against any Award paid to or on behalf of the Covered Individual to assure that Reimbursement is promptly made; and

(ii) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and

(iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all Awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan's advance payment of benefits for claims related to the Illness, Injury or other loss; and

(iv) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any Award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Reimbursement/Subrogation/Assignment Agreement. Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan including an executed

reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's Recovery Rights if the Plan, at its discretion, makes an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

(f) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.

(g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits; or

(ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee informed of all material developments with respect to all such claims, actions or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

(h) All Recovered Proceeds Are to be Applied to Reimburse the Plan. By accepting an advance payment of benefits for an Illness, Injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any Award paid or payable to or on behalf of such Covered Individual by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury or other loss with respect to which an Award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the Award was reasonable and the subsequent claims were not recognized in the Award.

(i) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan's Recovery Rights.

(j) No-Fault Insurance Coverage. Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses paid by this Plan up to the greater of:

(i) the maximum amount of basic reparation benefit required by applicable law, or

(ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.

If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual is considered as being self-insured and must pay the amount of any and all expenses paid by the Plan for any and all Covered Individuals arising out of the accident.

(k) Refund of Overpayment of Benefits – Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must make a refund to the Plan if:

(i) all or some of the expenses were not paid, or did not legally have to be paid, by the Covered Individual;

(ii) all or some of the payment made by the Plan exceeds the benefits under the Plan; or

(iii) all or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If a Covered Individual or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

ARTICLE VII

Special Compliance Provisions

7.1 Use and Disclosure of Protected Health Information. (a) Any health plan under the Plan shall use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

(b) Health Care Treatment. Health care treatment means the provision, coordination or management of health care and related services by one or more health care providers. It also includes coordination or management of health care by a health provider and a third party and consultation or referrals between one health care provider and another.

(c) Payment. Payment includes activities undertaken by any health plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits, or to obtain or provide reimbursement for the provision of health care, that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(i) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

(ii) coordination of benefits;

(iii) adjudication of health claims (including appeals and other payment disputes);

(iv) subrogation of health claims;

(v) establishing employee contributions;

(vi) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(vii) billing, collection activities and related health care data processing;

(viii) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(ix) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(x) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(xi) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(xii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(xiii) reimbursement to a health plan.

(d) Health Care Operations. Health care operations include, but are not limited to, the following activities:

(i) quality assessment;

(ii) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(iii) rating provider and health plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the health plan, including formulary development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the health plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected health information is not disclosed to such policyholder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

(e) A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a health plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the health plan.

(f) A health plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the health plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by the health plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a health plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the health plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA's access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the health plan's compliance with HIPAA;

(x) ensure that adequate separation between the health plan and the Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the health plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).

(g) Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the health plan. If such individuals do not comply with this health plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(h) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

7.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll in the Plan's group health coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees, Spouses and Dependents who are eligible but not enrolled in a group health plan listed in Appendix A may enroll when:

(i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules of this Section 7.2 do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide a child or children of an Employee with health insurance coverage. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group health plan's procedures for determining whether the medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee's, Spouse's or Dependent's eligibility for health coverage or health benefits under the Plan.

7.5 Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Spouse and Dependents as if such participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Employer.

If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she must be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

7.6 Special Rules for Maternity and Infant Coverage. Any health plan available under the Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as

applicable). Notwithstanding the foregoing, the health plan and issuers may not require that a provider obtain authorization from the health plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women's Health. If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

7.8 Military Leave.

A Participant's right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

(a) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(i) the 24-month period beginning on the Participant's first day of military leave, or

(ii) the period beginning on the Participant's first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(b) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage. If the Participant's absence is for 31 or more days, the Participant will be required to pay not more than 102% of the full cost of the group health plan coverage (and the Participant's Spouse and Dependents) under the Plan.

(c) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(d) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed had the Participant's coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the

Secretary of Veteran's Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

(e) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

7.9 COBRA.

(a) Legal Rights to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The Employer, to the extent required by law, shall offer a Participant and/or a Spouse or dependent child who, as a result of a "qualifying event," becomes otherwise ineligible to participate in a group health plan, as defined in Section 607(l) of ERISA, under the Plan the opportunity to temporarily extend coverage under such group health plan at group rates. A domestic partner shall not be considered a Spouse for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law. However, the Employer may, solely in its own discretion, and solely in the manner it determines, provide continuation coverage to domestic partners who are Plan beneficiaries.

(b) Qualifying Events.

(i) A Participant who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) A reduction of the Participant's hours of employment;

(B) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(C) Upon the Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired employee.

(ii) A Spouse who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;

(B) The death of the Participant;

(C) The divorce or legal separation of the Participant and Spouse;

(D) Enrollment in Medicare (Part A or B) by the Participant; or

(E) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(iii) A Participant's dependent child who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following events, shall be entitled to COBRA continuation coverage.

(A) The loss of Dependent status under the group health plan;

(B) The Participant's voluntary or involuntary termination for reasons other than gross misconduct, or the Participant's reduction of hours of employment;

(C) The death of the Participant;

(D) The divorce or legal separation of the Participant and Spouse;

(E) Enrollment in Medicare (Part A or B) by the Participant; or

(F) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(c) Qualified Beneficiary. A Qualified Beneficiary is a Participant, Spouse, or dependent child who on the day before a qualifying event is covered under a group health plan available under the Plan. Qualified Beneficiary includes children born to, adopted by, or placed for adoption with the Participant during his or her COBRA continuation coverage period. Such child's coverage period shall be determined according to the date that the Participant's COBRA continuation coverage period began. A domestic partner is not a Qualified Beneficiary for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage as described in this Article VII unless otherwise required under applicable law.

(d) Notices. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the group health plan available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.

The Qualified Beneficiary shall be notified of his or her right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the group health plan available under the Plan ceases or the date the Qualified Beneficiary is notified of the right to elect continuation coverage.

If the Qualified Beneficiary does not elect continuation coverage, coverage under the group health plan available under the Plan shall cease. If the Qualified Beneficiary chooses continuation coverage, such group health plan shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.

(e) Cost. The Qualified Beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

(i) A Qualified Beneficiary who loses group health plan coverage available under the Plan as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such group health plan and elects COBRA continuation coverage shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.

(ii) A Qualified Beneficiary who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each Qualified Beneficiary (other than a covered Employee). The Qualified Beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of group health plan coverage for the Qualified Beneficiary in the absence of the first qualifying event. In no event, however, shall any Qualified Beneficiary's COBRA continuation coverage period exceed 36 months.

(iii) A Qualified Beneficiary (other than the Participant) who loses group health plan coverage as a result of the Participant’s termination of employment or reduction of hours and such event occurs within 18 months following the Participant’s enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.

(iv) If a qualifying event occurs that is the Participant's termination of employment or reduction of hours, any Qualified Beneficiary who is deemed to have been

disabled, as determined by the Social Security Administration, at any time during the first 60 days of COBRA continuation coverage shall be eligible to extend the COBRA continuation coverage period to 29 months. In the case of a child born to or adopted by a Participant during the Participant's COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. Such extension shall apply to the Qualified Beneficiary's covered family members. Such Qualified Beneficiary must notify the Plan Administrator of the disability in writing within 60 days of the date of the Social Security Administration determination and before the end of the 18-month continuation coverage period. A Qualified Beneficiary receiving extended COBRA continuation coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.

(v) In the case of a qualifying event that is the bankruptcy of the Employer, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of—(A) The date of the Qualified Beneficiary's death; or (B) The date that is 36 months after the death of the retired covered employee.

(g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:

(i) The Employer ceases to provide group health plan coverage to any of its employees;

(ii) The Qualified Beneficiary fails to pay the premium or required contribution within 30 days after its due date;

(iii) The Qualified Beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary (other than an exclusion or limitation that may be disregarded under the law);

(iv) The Qualified Beneficiary becomes enrolled in Medicare after the date of the COBRA continuation coverage election;

(v) The Qualified Beneficiary has extended COBRA continuation coverage due to a disability and is subsequently determined by the Social Security Administration to be no longer disabled;

(vi) The maximum required COBRA continuation coverage period expires; or

(vii) For cause, such as fraudulent claim submission, that would result in termination of coverage for a similarly situated active employee.

(h) Second Election Period. A Participant and his or her covered family members may be eligible to elect continuation coverage during a second election period if such Participant:

(i) is receiving trade adjustment assistance benefits under the Trade Act of 2002 (or would be eligible to receive trade adjustment assistance benefits but has not exhausted unemployment benefits);

(ii) lost health coverage due to termination of employment that resulted in eligibility for trade adjustment assistance benefits under the Trade Act of 2002; and

(iii) did not elect COBRA continuation coverage during the initial COBRA election period.

The second election period is the 60-day period beginning on the first day of the month in which the Participant becomes eligible for such second election period, but only if the election is within the six-month period after the Participant initially lost coverage. COBRA continuation coverage begins on the first day of the second election period. Such coverage is not retroactive to the date the Participant initially lost coverage.

7.10 Genetic Information Nondiscrimination Act of 2008 ("GINA"). (a) Unless otherwise permitted, the Employer may not request or require any genetic information from an Employee or family member of the Employee.

(b) "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

(c) The Employer shall not request any genetic information when requesting health-related information. However, with respect to any wellness program available under the Plan, the Employer may request, but may not require, an Employee to provide genetic information in accordance with Equal Employment Opportunity Commission regulations.

(d) The Employer will not request, require or purchase genetic information in violation of GINA. If the Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Employer will not use such genetic information in violation of GINA. Any genetic information received by the Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

7.11 Health-Related Factors. The group health plan will not discriminate against any participant or dependent in terms of eligibility to participate in the plan based on a health-related factor. In addition, benefits provided under the group health plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The group health plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

7.12 Mental Health Parity Act. The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

ARTICLE VIII

Amendment and Termination

8.1 Amendment. The Employer has the right to amend the Plan at any time, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan, at the direction of an authorized officer of the Employer or an authorized designee.

8.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan (or any Welfare Program) for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE IX

Miscellaneous

9.1 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Spouses, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

9.2 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Spouse, Dependent or Beneficiary under the Plan 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 or, in the case of assignments, as permitted under the terms of a Welfare Program.

9.3 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer (or Participating Employer) except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer (or Participating Employer) to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

9.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of Arizona to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the state of Arizona.

9.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

9.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

9.7 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

9.8 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Employer, according to the Employer's determination.

ARTICLE X

Participating Employers

10.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer's governing body.

10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

10.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Welfare Program with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XI

Effective Date

The effective date of this Plan is July 01, 2019.

* * * * *

IN WITNESS WHEREOF, the Employer has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

Mammoth-San Manuel Unified School District

By: _____
Date: _____

ATTEST:

_____

APPENDIX A
MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as part of the Plan pursuant to Section 2.15 and as defined in Section 2.19:

Welfare Programs
Medical Plan

Carrier's or Program Administrator's Name:	Meritain Health
Contract Number:	13690
Address:	18444 N. 25th Ave, Suite 410 Phoenix, Arizona 85023 (602) 789-1170 http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Prescription Drug Plan

Carrier's or Program Administrator's Name:	Meritain Health
Contract Number:	13690
Address:	18444 N. 25th Ave, Suite 410 Phoenix, Arizona 85023 (602) 789-1170 http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Health Savings Account (HSA) Contributions

Carrier's or Program Administrator's Name:	Health Equity
Address:	15 W. Scenic Pointe Drive,, Suite 400 Draper, Utah 84020 (866) 346-5800 https://www.healthequity.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Dental Plan

Carrier's or Program Administrator's Name:	Sun Life Financial
Contract Number:	5463182
Address:	One Sun Life Executive Park Wellesley Hills, Massachusetts 02481 (800) 247-6875 http://www.sunlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Vision Plan

Carrier's or Program Administrator's Name: Meritain Health
Contract Number: 13690
Address: 18444 N. 25th Ave, Suite 410
Phoenix, Arizona 85023
(602) 789-1170
http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Life Insurance Plan

Carrier's or Program Administrator's Name: Reliance Standard
Contract Number: 151487
Address: 4222 E. Thomas Rd., Suite 390
Phoenix, Arizona 85018
(602) 467-4700
http://www.reliancestandard.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Health Care Flexible Spending Account

Carrier's or Program Administrator's Name: BASIC
Address: 2526 E. Lee Street
Tucson, Arizona 85716
(800) 473-0455
http://www.basiconline.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Dependent Care Reimbursement Account (DCRA) Plan

Carrier's or Program Administrator's Name: BASIC
Address: 2526 E. Lee Street
Tucson, Arizona 85716
(800) 473-0455

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Premium Conversion Plan

Carrier's or Program Administrator's Name: Aflac
Address: 1932 Wynnton Road
Columbus, Georgia 31999
(800) 992-3522
https://www.aflac.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

APPENDIX B
MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

PARTICIPATING EMPLOYERS

In addition to Mammoth-San Manuel Unified School District, the following Participating Employers have adopted the Plan pursuant to Section 10.1:

There are no other employers participating in the Plan.

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

WRAP SUMMARY PLAN DESCRIPTION

Mammoth-San Manuel Unified School District
PO Box 406
San Manuel, Arizona 85631

V03052018

FOREIGN LANGUAGE ASSISTANCE NOTICE

Spanish:
Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo su Programa de Beneficio Social. Si encuentra alguna dificultad para entender cualquier parte de este folleto, póngase en contacto con su Administrador(a) del Plan. Para mayor información, por favor póngase en contacto con: (520) 385-2337

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

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MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

WRAP SUMMARY PLAN DESCRIPTION

This document, along with the benefits booklets and certificates, and provider contracts, policies and descriptions, is the summary plan description ("SPD") for the Mammoth-San Manuel Unified School District Welfare Benefit Plan (the "Plan"). These documents describe the Plan as in effect on July 01, 2019. The Plan may be changed from time to time.

Because the benefits you receive through the Plan will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans.

For additional information regarding the Plan, you should contact the Business Manager at (520) 385-2337 or refer to the Welfare Program documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

GENERAL PLAN INFORMATION

Type of Plan:	Welfare, including the following Welfare Programs: Medical Plan, Prescription Drug Plan, Health Savings Account (HSA) Contributions, Dental Plan, Vision Plan, Life Insurance Plan, Health Care Flexible Spending Account, Dependent Care Reimbursement Account (DCRA) Plan, Premium Conversion Plan as enumerated in Appendix A
Plan Name:	Mammoth-San Manuel Unified School District Welfare Benefit Plan (the "Plan")
Plan Number:	501
Plan Year:	The Plan Year is the twelve month period ending June 30.
Plan Sponsor:	Mammoth-San Manuel Unified School District (the "Employer") PO Box 406 San Manuel, Arizona 85631 (520) 385-2337 For a list of Participating Employers, please refer to Appendix B.
Plan Sponsor's Employer	

Identification Number:	86-6000557
Plan Administrator:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337
Agent for Service of Legal Process:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337 Service of legal process may also be made upon the Plan Administrator.
Plan Administration:	Welfare Programs available under the Plan are administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers or providers who provide and guarantee the benefits. Self-insured or unfunded benefits, if any, are paid from the Employer's general assets.
Claims Administrators:	See chart below and/or the separate summary that may apply to a particular type of coverage.

For Claims On	Claims Administrator Name	Contact
Medical Plan	Meritain Health	(602) 789-1170
Prescription Drug Plan	Meritain Health	(602) 789-1170
Health Savings Account (HSA) Contributions	Health Equity	(866) 346-5800
Dental Plan	Sun Life Financial	(800) 247-6875
Vision Plan	Meritain Health	(602) 789-1170
Life Insurance Plan	Reliance Standard	(602) 467-4700
Health Care Flexible Spending Account	BASIC	(800) 473-0455
Dependent Care Reimbursement Account (DCRA) Plan	BASIC	(800) 473-0455

Premium Conversion Plan	Aflac	(800) 992-3522

ELIGIBILITY AND BENEFITS

An Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to a particular type of coverage under the Plan and the Participant makes the required employee contribution for the coverage selected. The Plan Administrator will inform you of the amount of required employee contributions, if any, for each type of coverage. Detailed information with descriptions of benefits and eligibility requirements for each type of benefit are contained in the relevant benefits booklets and certificates, provider contracts and benefit descriptions. Copies of these documents are also available, without charge, from the Plan Administrator, upon request.

To the extent required by applicable law under the Patient Protection and Affordable Care Act ("ACA"), for certain companies with 50 or more full-time Employees, the number of hours worked to obtain full-time status for group health plan coverage purposes will be determined in accordance with certain measurement rules adopted by the Employer for all Employees (including variable hour and seasonal employees, if such classes exist within the Employer). A temporary Employee is not eligible for coverage if he or she is eligible for health coverage through a leasing company, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations. This eligibility information is available upon request to the Plan Administrator.

If the Employer utilizes the measurement rules under the "look-back" method as permitted by the ACA and its accompanying regulations, each Employee's hours of service in a prior period (called the "measurement period") will be calculated to determine the status of the Employee during a future period (called the "stability period"). The Employer may also utilize an additional time period (called the "administrative period"), between the measurement period and the stability period, to complete administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. Employees whose hours are variable or otherwise uncertain at their start dates (e.g., "variable hour" or "seasonal" Employees) will not initially be eligible for coverage during the applicable measurement period—if it is determined during the measurement period (and any associated administrative period, if applicable) that such Employees are considered to be full-time, they will be offered coverage during their subsequent stability period.

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each type of coverage for the enrollment of eligible Employees, their Spouses or Dependents, if any, and will communicate these procedures to eligible Employees. The Plan Administrator will prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

DISCRIMINATION BASED ON HEALTH-RELATED FACTORS PROHIBITED

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any participant or dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under your Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

HIPAA PRIVACY ISSUES

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself, your Spouse or Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Dependents in this plan if you or your Spouse or Dependents lose eligibility for that other coverage (or

if the Employer stops contributing towards your or your Spouse's or Dependents' other coverage). However, you must request enrollment within 30 days after your or your Spouse's or Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Spouse and Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your Spouse or Dependents are eligible, but not enrolled, in the Group Medical Plan listed in Appendix A you may enroll when:

- Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after the termination, or
- You or your Spouse or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (*e.g.*, spending accounts that limit benefits to employee salary reduction amounts).

To request special enrollment or obtain more information, contact the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide coverage to a child or children of an Employee. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Employee and the child (or child's guardian) of the receipt of any medical child support order, and the group medical plan's procedures for determining whether a medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Employee and the child of such determination.

STATE MEDICAID PROGRAMS

Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a Spouse's or Dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

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

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan's policy, contact the Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

HEALTH COVERAGE DURING UNPAID FMLA LEAVE

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive group health coverage for yourself and your covered Spouse and Dependents. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you may then be eligible for COBRA continuation coverage (as described below). To receive group health plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium. You should contact the Plan Administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your group health plan coverage or other types of coverage during unpaid FMLA leave, your coverages will be reinstated when you return from FMLA leave. For additional information about Plan coverage during FMLA leave, contact the Plan Administrator.

Additional family and medical leave rights may apply under state law. Please contact the Plan Administrator for further information.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (*e.g.*, family and medical leave).

COBRA CONTINUATION COVERAGE

Under a federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), group health plans of most employers with 20 or more employees are generally required to offer covered Employees, their covered Spouses and Dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good

health is not required for this extension. Domestic partners should contact the Plan Administrator to discuss eligibility for continuation coverage.

As an Employee covered under the Plan, you may have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your Spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses Dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your Spouse divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted by, or placed for adoption with the covered Employee during the continuation coverage period may also be entitled to elect COBRA continuation coverage. Such child's coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee's COBRA coverage. You must notify the Plan Administrator within 30 days and provide supporting documentation.

Under COBRA, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator by filing a Change of Status notice with the Plan Administrator within 60 days after:

- You and your Spouse are divorced or legally separated; or
- One of your children loses Dependent status under the Plan.

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period. However, you (or your Spouse or dependent child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of the total premium paid by you and your Employer for that level of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Spouse or dependent child, if applicable) lose health coverage under the Plan because your employment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.) If during those 18 months, another qualifying event takes place that entitles your Spouse (or dependent child, if applicable) to continuation health coverage, your Spouse's continuation coverage (or dependent child's continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your Spouse's health continuation coverage (or your dependent child's health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event. If your covered Spouse and/or dependent child lose coverage due to your termination of employment (for reasons other than gross misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in Medicare, then the maximum continuation coverage period for your Spouse and dependent child shall be 36 months from the date you enrolled in Medicare.

Disability is a special issue. If the Social Security Administration determines that you (or your Spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after a child's birth, adoption or placement for adoption, then your continuation coverage period as well as your Spouse's and any Dependent's continuation periods may be extended from 18 months to 29 months. The Employer may charge up to 150% of the total premium paid by you and the Employer during this extended period. To qualify, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator in writing within 60 days of the date of the Social Security Administration

determination and during the initial 18 month continuation coverage period. Your written notice must include your name, Social Security Number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the Employer will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage was the bankruptcy of the Employer under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until the death of the covered retired employee. Covered spouses, surviving spouses and dependents of the covered retired employee will have the opportunity to elect continuation health coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

Your right to continuation health coverage (or your Spouse's or dependent child's right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

In order to protect your family's rights, you should keep the Plan Administrator/COBRA Administrator informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send the Plan or COBRA Administrator.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additional continuation rights may apply under state law. Please contact the Plan Administrator for further information.

CLAIMS PROCEDURES FOR THE PLAN

Except as provided below, claims for benefits under each Plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification 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. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DETERMINATION OF DISABILITY

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification regarding the claim denial. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan's appeals procedures. The discussion of the claim denial will also include:

- if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;
- the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and

- 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 claimant's claim for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Claim Denial Notices

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level

appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

SUBROGATION/REIMBURSEMENT

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you may be required to reimburse the Plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the health benefits you collect from the third party responsible for the accident, or from his or her insurance company, or anyone else from which you receive payment for the accident. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party.

For additional information about subrogation/reimbursement, contact the Plan Administrator.

PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate

in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Welfare Programs. However, all previous salary deductions will be used to pay for Welfare Programs that you have elected.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage under the Plan if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to make required contributions;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefit claims;
- You cease to be an eligible Employee; or
- The Plan terminates.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the benefits booklet gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

⇒ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

⇒ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

APPENDIX A
MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as comprising the Plan:
Medical Plan
Prescription Drug Plan
Health Savings Account (HSA) Contributions
Dental Plan
Vision Plan
Life Insurance Plan
Health Care Flexible Spending Account
Dependent Care Reimbursement Account (DCRA) Plan
Premium Conversion Plan

APPENDIX B
MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT WELFARE BENEFIT PLAN

PARTICIPATING EMPLOYERS

In addition to Mammoth-San Manuel Unified School District, the following Participating Employers have adopted the Plan:

There are no other employers participating in the Plan.

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT

PREMIUM CONVERSION AND HEALTH SAVINGS ACCOUNT CONTRIBUTION PLAN

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT
PREMIUM CONVERSION AND
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MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT
PREMIUM CONVERSION AND
HEALTH SAVINGS ACCOUNT CONTRIBUTION PLAN

Mammoth-San Manuel Unified School District (the "Employer") hereby sets forth the Mammoth-San Manuel Unified School District Premium Conversion and Health Savings Account Contribution Plan, as in effect July 01, 2019.

ARTICLE I

Purpose

The purpose of this Plan is to enable Eligible Employees to elect to receive part of their compensation in the form of pre-tax benefits and health savings account contributions. The Plan is intended to be a "cafeteria plan" as described in Section 125 of the Code, as amended, as well as any rulings and regulations promulgated thereunder.

This Plan is a "Welfare Program" offered under Mammoth-San Manuel Unified School District Welfare Benefit Plan (the "Welfare Plan"), and is incorporated therein by reference.

ARTICLE II

Definitions

2.1 "Beneficiary" means a beneficiary as defined under a Benefit Option.

2.2 "Benefit Contributions" means credits to the Benefits Account on behalf of a Participant pursuant to the Participant's Participation Agreement.

2.3 "Benefit Option" means any benefit listed in Exhibit A and for which an Eligible Employee may elect to make pre-tax contributions pursuant to Article VI and Article XII of the Plan.

2.4 "Benefits Account" means an account maintained on the books of the Employer for each Participant in accordance with Article VII for the purpose of recording the Participant's Benefit Contributions. A subaccount shall be established hereunder with respect to each Benefit Option elected by a Participant.

2.5 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.6 "Dependent" means a dependent as defined under a Benefit Option. However, for purposes of any Benefit Option that provides medical benefits, Dependent shall also include a Participant's children who have not attained age 26 (or such later age as determined by the Plan Administrator).

2.7 "Eligible Employee" means an Employee described in Section 3.1.

2.8 "Employee" means any person providing services to the Employer or Participating Employer as a common-law employee. Non-resident aliens, independent contractors and individuals designated by the Employer as temporary employees shall not be Employees for purposes of this Plan. Leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and employees subject to collective bargaining agreements may be included in the definition of Employee only at the discretion of the Employer.

2.9 "Employer" means Mammoth-San Manuel Unified School District, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

2.10 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.11 "Health Savings Account" or "HSA" means a tax-exempt trust or custodial account under Section 223 of the Code that is established with a qualified HSA trustee or custodian.

2.12 "High Deductible Health Plan" means a health plan that meets the statutory limits for annual deductibles and out-of-pocket expenses for individual coverage or for family coverage, as defined in Section 223(c)(2) of the Code.

2.13 "HSA-Eligible Individual" means a Participant who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage.

2.14 "Participant" means an Eligible Employee who has satisfied the requirements of Article III, entered into a Participation Agreement in accordance with Article IV, and whose participation has not terminated in accordance with Section 4.5.

2.15 "Participating Employer" means the term as defined in the Welfare Plan.

2.16 "Participation Agreement" means an electronic or written agreement entered into pursuant to Article IV, whereby an Eligible Employee agrees to reduce his or her cash compensation for the applicable Period of Coverage in consideration for the provision of a Benefit Option selected by the Eligible Employee.

2.17 "Period of Coverage" means the Plan Year; provided, however, that with respect to a Participant who commences participation after the beginning of the Plan Year, the initial Period of Coverage shall run from the effective date of the Participant's properly completed and executed Participation Agreement to the end of that Plan Year, and all subsequent Periods of Coverage shall be on the Plan Year basis; provided, further, that if a Participant modifies or revokes his or her Participation Agreement as permitted in Article VIII, a new Period of Coverage begins as of the effective date of such modification or revocation and shall run until the end of the Plan Year.

2.18 "Plan" means the Mammoth-San Manuel Unified School District Premium Conversion and Health Savings Account Contribution Plan as set forth herein and as amended from time to time.

2.19 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.20 "Plan Year" means the twelve consecutive month period ending on June 30.

2.21 "Spouse" means the individual who is legally married to an Eligible Employee under applicable law. Notwithstanding anything to the contrary contained herein, the term "Spouse" shall include a same-sex spouse who is legally married under applicable law.

ARTICLE III

Eligibility

3.1 Service Required to Become an Eligible Employee. Subject to Section 3.2, an Employee is eligible to participate in the Plan if he or she is eligible for coverage under a Benefit Option and meets any additional requirements under the provisions of Section 3.2.

3.2 Eligible Classification. Notwithstanding Section 3.1, an Employee shall not be an Eligible Employee while he or she is a member of a classification of Employees which the Plan Administrator has designated as not currently eligible to participate in the Plan. The Plan Administrator may at any time and from time to time remove any one or more Employees or group(s) or class(es) of Employees from eligibility for participation in this Plan, provided that in no event shall any such removal reduce the amount theretofore credited to the Benefits Account of any Participant.

3.3 Determination of Eligibility by Plan Administrator. The determination of an Employee's eligibility to become and continue as a Participant in the Plan shall be made by the Plan Administrator from the Employer's or Participating Employer's records, and the Plan Administrator's determination shall be binding and conclusive upon all persons.

ARTICLE IV

Participation

4.1 Election to Participate. If an initial Participation Agreement is required by the Plan Administrator, an Eligible Employee who files a properly completed and executed Participation Agreement with the Plan Administrator shall have elected to participate in the Plan and to reduce his compensation by the amount necessary to provide the elected Benefit Option(s) and to make HSA contributions. An Eligible Employee entitled to participate in the Plan pursuant to Section 3.1 must file a properly completed and executed Participation Agreement with the Plan Administrator within 30 days of his or her date of hire, within 30 days of his or her

otherwise becoming an Eligible Employee or within such other time period as determined by the Plan Administrator. Such Participation Agreement shall be binding for the Period of Coverage to which it applies and may not be modified or revoked by the Participant or by the Employer or Participating Employer, except as provided in Article VIII, Article X, or Article XII.

If an initial Participation Agreement is required by the Plan Administrator and an Eligible Employee does not enroll in the Plan when initially eligible, then he or she may enroll in the Plan as of the first day of a succeeding Plan Year by filing a properly completed and executed Participation Agreement with the Plan Administrator during an open enrollment period preceding such Plan Year. After initially eligible, an Eligible Employee may timely file a new properly completed and executed Participation Agreement with the Plan Administrator to enter the Plan during a Plan Year only in accordance with Article VIII or Article XII.

4.2 Elections for Subsequent Plan Years. If an initial Participation Agreement is required by the Plan Administrator, with the exception of HSA contribution elections under Article XII, if a Participant fails to file a new properly completed and executed Participation Agreement for a subsequent Plan Year, the existing Participation Agreement shall remain in effect for such subsequent Plan Year. The Plan Administrator may, at its discretion, require Eligible Employees to file new properly completed and executed Participation Agreements during an open enrollment period in order to continue benefits under the Plan.

4.3 Elections For Rehires. If a terminated Eligible Employee is rehired by the Employer or Participating Employer as an Eligible Employee within 30 days of his or her termination date, the Eligible Employee's Participation Agreement (if required) that was in effect on the day he or she terminated shall be reinstated. An Eligible Employee who is rehired as an Eligible Employee more than 30 days following termination of employment may file a new Participation Agreement (if required) with the Plan Administrator in accordance with Section 4.1.

4.4 Effective Date for Participation Agreements. If an initial Participation Agreement is required by the Plan Administrator, a Participation Agreement shall be effective as of the first day of the payroll period after the Eligible Employee files such properly completed and executed Participation Agreement with the Plan Administrator, or such later date as the Plan Administrator may prescribe, provided, however, that the effective date complies with applicable law.

4.5 Termination of a Participation Agreement. A Participation Agreement terminates on the earlier of:

(a) the end of the Plan Year, unless automatically reinstated in accordance with Section 4.2,

(b) the date the Participant revokes his or her Participation Agreement in accordance with Article VIII or Article XII,

(c) the date the Participant terminates employment with the Employer or Participating Employer,

(d) the date the Participant ceases to be an Eligible Employee, or

(e) the date the Plan terminates in accordance with Article X.

ARTICLE V

Funding

The Employer shall contribute to the cost of the Benefit Option(s) provided under the Plan to the extent of, and pursuant to, each Participant's Participation Agreement.

ARTICLE VI

Benefit Options

6.1 Benefit Options. The Benefit Option(s) available under the Plan for which an Eligible Employee may choose pre-tax contributions in lieu of cash compensation may include any or all of the plans or programs listed in Exhibit A which are Welfare Programs under the Welfare Plan which the Employer, in its sole discretion, may make available from time to time.

6.2 Controlling Documents. While the Participant's election to make pre-tax contributions to pay for one or more Benefit Options may be made pursuant to this Plan, the Benefit Options will be provided not by this Plan but instead by the respective benefit plans or programs constituting the Benefit Option. Such benefit plans or programs, if and as implemented and in effect from time to time, shall be set forth in written instruments or in insurance policies or contracts which shall be filed with or attached as appendices or schedules to the Welfare Plan. The types and amounts of benefits available under each available Benefit Option, the requirements for coverage and receiving benefits under the Benefit Option, and the other terms and conditions pertaining thereto, shall be as set forth in the written instruments or in the insurance policies or contracts comprising the respective plans or programs.

ARTICLE VII

Contributions Towards Benefit Options

7.1 Benefit Contributions for Benefit Options. If a Participant elects a Benefit Option as identified in Exhibit A, the Participant's cash compensation will be reduced by the amount the Participant specifies (subject to any applicable limits imposed by the Plan Administrator or otherwise), or by the amount the Plan Administrator specifies as the Participant's cost of the Benefit Option, and an amount equal to the reduction will be credited to the appropriate subaccount established under the Participant's Benefits Account. Amounts allocated to each such subaccount shall remain segregated in such subaccount and may not be commingled with or transferred to any other subaccount under any circumstances. Amounts credited to each subaccount shall be applied to the next premium, payment, or expense, or shall be reimbursed to

the Participant, as specified under the relevant Benefit Option. The subaccount shall thereupon be debited and reduced to its new balance.

7.2 Payment for Benefits With After-Tax Contributions. Notwithstanding any other provision of this Plan, the Employer may maintain and offer to its Eligible Employees the opportunity to obtain coverage under any employee benefit plan, including, without limitation, Benefit Options, pursuant to the Eligible Employee's agreement to pay for such coverage with after-tax employee contributions. If any Benefit Option covers domestic partners, the Participant shall pay for the cost of such Benefit Option elected on behalf of a domestic partner with after-tax contributions, unless permitted to use pre-tax dollars in accordance with applicable federal or state law.

7.3 Medical Care Plan Continuation Coverage. Nothing contained in this Plan is intended to limit or affect the rights, if any, of a Participant or his or her covered Spouse or Dependents to continuation of coverage under any group health plan sponsored by the Employer. Such rights to continuation of coverage shall be governed by the terms of such Benefit Option(s) and by applicable law.

ARTICLE VIII

Modification or Revocation of Participation Agreement

8.1 Limitations. A Participation Agreement shall remain in effect unless modified or revoked by a Participant as provided in this Article. With the exception of an HSA contribution election, an Eligible Employee may modify or revoke a Participation Agreement with respect to the current Period of Coverage only in accordance with Section 8.2 or, if applicable, Sections 8.3 to 8.5. For purposes of this Article, Spouse does not include domestic partners, unless recognized as such under federal law.

8.2 Modification or Revocation of Participation Agreement. If permitted under a particular Benefit Option, an Eligible Employee may modify or revoke a Participation Agreement during a Plan Year within 30 days after the occurrence of one of the events described in this Section or, if longer, within the period required by applicable law, as follows:

(a) An Eligible Employee may modify or revoke a Participation Agreement during a Plan Year with respect to the Benefit Option(s) under the Plan if one of the following "change in status events" occurs and the modification or revocation satisfies the consistency requirement of paragraph (b) below:

(i) a change in the Eligible Employee's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) a change in the number of the Eligible Employee's Dependents, including due to the birth, adoption, placement for adoption, or death of a Dependent;

(iii) a change in employment status of the Eligible Employee, his or her Spouse, or a Dependent, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) a Dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of a specified age, student status, or any similar circumstance as provided in the applicable Benefit Option;

(v) the Eligible Employee, his or her Spouse or a Dependent changes his or her place of residence, but only if such change affects the person's eligibility for coverage under a Benefit Option; or

(vi) Any other event that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

(b) With respect to the Benefit Options under the Plan, an Eligible Employee's modification or revocation of his or her Participation Agreement during the Plan Year is consistent with the change in status event, and thus permissible, only if the election change is on account of and corresponds with a change in status event that affects eligibility for coverage under one of the Benefit Options or under a plan maintained by the Spouse's or Dependent's employer. A change in status event that affects eligibility under a Benefit Option or a plan maintained by the Spouse's or Dependent's employer shall include a change in status event that results in an increase or decrease in the number of an Eligible Employee's family members or Dependents who may benefit from coverage under the Benefit Option(s). With respect to any group term life insurance or group disability insurance identified in Exhibit A, an election by an Eligible Employee to either increase or decrease coverage in response to a change in status event is deemed to correspond with that change in status.

(c) An Eligible Employee may modify or revoke his or her Participation Agreement with respect to the group health plans identified in Exhibit A if the modification or revocation results from and is consistent with a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order, as defined in Section 609(a) of ERISA) that requires group health plan coverage for the Eligible Employee's child or foster child who is a dependent of the Eligible Employee. The Eligible Employee may modify or revoke his Participation Agreement during the Plan Year in order to:

(i) provide group health coverage for the child if the order requires coverage for the child under the Eligible Employee's plan; or

(ii) cancel group health plan coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child, and the coverage is, in fact, provided.

(d) If the Participant, his or her Spouse or Dependent becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act ("Medicare") or Title XIX of the Social Security Act ("Medicaid") (other than coverage only for pediatric vaccines), the Participant may modify or revoke his or her Participation Agreement with respect to group health plan coverage to cancel coverage of the individual who becomes enrolled under Medicare or Medicaid. If an Eligible Employee, his or her Spouse or Dependent loses coverage described in the preceding sentence, the Eligible Employee may file a new Participation Agreement with respect to group health plan coverage in order to begin or increase coverage of that individual who lost coverage under Medicare or Medicaid.

(e) The Participant may modify or revoke his or her Participation Agreement with respect to a Benefit Option listed in Exhibit A if there are significant cost increases or decreases charged to the Participant for such Benefit Option. Permitted changes include: commencing participation in the Plan for a Benefit Option that decreases in cost, or, in the case of a Benefit Option that increases in cost, revoking an election for coverage and instead receiving, on a prospective basis, coverage under another Benefit Option providing similar coverage or dropping coverage if no such other Benefit Option providing similar coverage is available.

(f) If a Participant or a Participant's Spouse or Dependent has a significant curtailment of coverage under a Benefit Option during a Period of Coverage that is not a loss in coverage (*e.g.*, a significant increase in the deductible, the required co-payments, or the out-of-pocket cost sharing limit under a group health plan), any Participant who had elected that Benefit Option may modify or revoke his or her election for that coverage and instead elect to receive, on a prospective basis, coverage under another Benefit Option providing similar coverage. Coverage under a Benefit Option is significantly curtailed only if there is an overall reduction in coverage provided under the Benefit Option so as to constitute reduced coverage generally. The loss of one particular physician in a health network is not a significant curtailment.

(g) If a Participant or a Participant's Spouse or Dependent has a significant curtailment of coverage under a Benefit Option during a Period of Coverage that is a loss in coverage, the Participant may modify or revoke his or her Participation Agreement under the Plan and instead elect either to receive on a prospective basis coverage under another Benefit Option providing similar coverage or to drop coverage if no similar Benefit Option is available. A loss of coverage means a complete loss of coverage under a Benefit Option, including the elimination of the Benefit Option or an HMO ceasing to be available in the area where the individual resides. For purposes of this paragraph, a loss of coverage also includes:

(i) a substantial decrease in medical care providers available under the Benefit Option;

(ii) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant, Spouse or Dependent is currently undergoing a course of treatment; or

(iii) any other similar fundamental loss of coverage.

(h) If the Plan adds a new Benefit Option or if coverage under an existing Benefit Option is significantly improved during a Period of Coverage, an Eligible Employee may modify or revoke his or her Participation Agreement with respect to that Benefit Option and, on a prospective basis, elect coverage under the new or improved Benefit Option.

(i) If an Eligible Employee's Spouse or Dependent makes an election change under an applicable welfare plan or Section 125 plan maintained by such individual's employer, the Eligible Employee may modify or revoke his or her Participation Agreement if the change is on account of and corresponds with the election change made by the Eligible Employee's Spouse or Dependent, provided that the Spouse or Dependent's election change satisfies the regulations and rulings under Section 125 of the Code or the period of coverage under the other employer's applicable welfare plan or Section 125 plan does not correspond to the Period of Coverage under this Plan.

(j) In the event that an Eligible Employee, his or her Spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Eligible Employee may elect health coverage identified in Exhibit A for the balance of the Plan Year for the Eligible Employee, his or her Spouse or Dependent.

(k) An Eligible Employee may elect group health plan coverage listed in Exhibit A for the balance of the Plan Year for the Eligible Employee, his or her Spouse and/or Dependent if:

(i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the Eligible Employee requests coverage under the group health plan listed in Exhibit A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the Eligible Employee requests coverage under the group health plan listed in Exhibit A within 60 days after eligibility is determined.

(l) The Participant may revoke his or her Participation Agreement, with respect to a group health plan identified in Exhibit A that provides minimum essential coverage as defined under the Patient Protection and Affordable Care Act of 2010, if the Participant has been in an employment status under which he or she was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that he or she will reasonably be expected to average less than 30 hours of service per week after the change (regardless of whether this results in the loss of eligibility for the current group health plan), provided that the revocation of the election of coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(m) The Participant may revoke his or her Participation Agreement, with respect to a group health plan identified in Exhibit A that provides minimum essential coverage, if the Participant is eligible for a special enrollment period to enroll in a qualified health plan through a Health Insurance Marketplace pursuant to guidance issued by the U.S. Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a Health Insurance Marketplace during the Marketplace's annual open enrollment period, provided that the revocation of the election of coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in a qualified health plan through a Health Insurance Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(n) An Eligible Employee who otherwise is entitled to modify or revoke his or her Participation Agreement under (e) through (h) must do so within 30 days of receipt of written notice, from the Plan Administrator, of the significant change in cost or composition of the benefit originally elected. Accordingly, the Plan Administrator shall have the affirmative duty of providing Eligible Employees with written notification of such changes as soon as administratively feasible.

(o) Any modification or revocation of a Participation Agreement under this Section shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

8.3 Continuation Health Coverage. If the Employer so permits and the Participant, Spouse or Dependent becomes eligible for continuation coverage under a Benefit Option that is a group health plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or any similar state law, the Participant may elect to increase payments under such group health plan(s) to pay for continuation coverage.

8.4 Family and Medical Leave Act of 1993 ("FMLA"). A Participant who takes an unpaid leave of absence under FMLA may revoke his or her Participation Agreement at the beginning of or during the leave. Such a revocation is binding on the Participant for the balance of the Plan Year and may not be changed until the next Period of Coverage, except for a revoked election under a group health plan which the Participant shall have the right to reinstate at the end of the FMLA leave period.

If a Participant chooses to continue coverage under the Employer's group health plan during an unpaid leave of absence under FMLA, the Plan Administrator shall select among the following options for required payments during the leave of absence:

(a) Pre-payment by the Participant before the commencement of the leave through pre-tax or after-tax payments under a Participation Agreement, from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met; provided, however, that pre-payment shall not be the sole option offered to a Participant on FMLA leave;

(b) Payment by the Participant of required payments during the leave on the same schedule as payments would be made if the Participant were not on leave, or under another schedule permitted under Department of Labor regulations. The Employer shall not be required to continue group health plan coverage of a Participant who fails to make required payments while on FMLA leave. However, if the Employer chooses to continue such coverage of a Participant who fails to make required payments while on FMLA leave, the Employer is entitled to recover those payments after the Participant returns from FMLA leave by payroll deduction; or

(c) Advancement by the Employer of the Participant's required payments while the Participant is on FMLA leave. The Employer shall be entitled to recover such advanced amounts when the Participant returns from FMLA leave by payroll deduction.

8.5 Military Leave. (a) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage in accordance with Section 8.4.

(b) Participants returning from military leave shall be reinstated upon re-employment.

(c) In no event shall benefits available under this Plan during a period of qualified military leave be less generous than those benefits available during other comparable employer-approved leave periods (*e.g.*, family and medical leave).

ARTICLE IX

Claims Procedure

9.1 Written Claim for Benefits. If a Participant asserts a right to any benefit under the Plan which he or she has not received, the Participant must file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written notice to the claimant within 90 days (or longer if the situation so requires but not longer than 180 days) of the receipt by the Plan Administrator of the application. The Plan Administrator shall set forth in the notice:

(a) the specific reason(s) for the denial of the claim,

(b) the specific reference to pertinent provisions of the Plan on which the denial is based,

(c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and

(d) an explanation of the Plan's claims review procedure.

9.2 Review of Denied Claim. A Participant whose application for benefits is denied, in whole or in part, may request a full and fair review of the decision denying the claim within 60 days after receipt of the notice of the denial from the Plan Administrator. The Participant may:

(a) request a hearing by the Plan Administrator upon written application to the Plan Administrator,

(b) review pertinent documents in the possession of the Plan Administrator, or

(c) submit issues and comments in writing to the Plan Administrator for review.

A decision on review by the Plan Administrator shall be made promptly but not later than 60 days after the receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant will be so notified of the extension, and a decision shall be rendered as soon as possible but not later than 120 days after the receipt of the request for review. The decision shall be in writing and shall include specific reasons for the decision written in a manner calculated to be understood by the Participant and specific reference to the pertinent provisions of the Plan on which the decision is based. The Plan Administrator's decision shall be final and binding upon all parties.

9.3 Claims Under Benefit Options. The foregoing provisions of this Article describe the procedures for claiming the entitlements offered under this Plan, that is, salary reduction to enable Participants to pay their cost of Benefit Options with pre-tax income. A Participant or any Spouse, Dependent or Beneficiary shall make claims for actual benefits under the specific terms and claims review procedures of the Employer's benefit plans or programs which form the Benefit Option.

ARTICLE X

Amendment and Termination

10.1 Amendment. The Employer has the right to amend the Plan at any time to the extent that it may deem advisable, including the right to amend any of the Benefit Options or to transfer any Benefit Option(s) from the Plan into a separate, related plan. Any amendment shall be at the direction of an authorized officer of the Employer or an authorized designee.

10.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Benefits Options, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE XI

Spendthrift Provision

A Participant's rights to pay for Benefit Options under the Plan with pre-tax compensation shall not be assignable or subject to attachment or receivership, nor shall they pass to any trustee in bankruptcy or be reached or applied by any legal process for the payment of any obligations of the Participant.

ARTICLE XII

Health Savings Account Contributions

12.1 HSA Contributions. A Participant who is an HSA-"Eligible Individual," as defined in Code Section 223, may participate in the HSA portion of the Plan by electing to make contributions on a pre-tax basis to an HSA established and maintained outside of the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited. An Eligible Individual may not have any disqualifying coverage and must be covered by a High Deductible Health Plan. For these purposes, a "High Deductible Health Plan" is a health plan that meets the statutory limits for annual deductibles and out-of-pocket expenses for individual coverage or for family coverage, as defined in Code Section 223 and section 1302(c)(1) of the Affordable Care Act. Disqualifying coverage may include coverage under a Spouse's group health plan or a general purpose health care flexible spending account offered under the Employer's, or Spouse's, Code Section 125 cafeteria plan.

Additionally, the Employer may elect, in its sole discretion, to make contributions to Participants' HSA accounts as permitted by applicable law, in any amount and manner and at any time, as limited by Section 12.3.

12.2 Relationship to Health Care Flexible Spending Account Benefits. HSA contributions may not be elected by Participants who are also covered by a health care flexible spending account unless the health care flexible spending account is designed to be compatible with an HSA (e.g., a "Limited Purpose Health FSA"), as defined in IRS Revenue Ruling 2004-45 and subsequent law or IRS guidance.

12.3 Maximum Contributions for HSAs and Election Modifications. The annual total contribution to a Participant's HSA may not exceed the statutory maximum amount as set forth in IRS guidance and Code Section 223(b). An additional catch-up contribution may be available for Participants who are age 55 or older. In addition, the maximum annual contribution shall be reduced by matching (or other) Employer contributions, if any, made on the Participant's behalf to the HSA. An election to initiate or change an HSA contribution election can be made at any time, and will be effective on the first day of the calendar month following the election.

12.4 Recording Contributions for HSAs. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward Participants' contributions. Such a list is not an endorsement

of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA contributions a Participant makes, but it will not create a separate fund or otherwise segregate assets for this purpose.

12.5 Tax Treatment of HSA Contributions and Distributions. The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

12.6 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan. An HSA is not an Employer-sponsored benefit plan. It is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan for the electing Participant. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. Terms and conditions of coverage and benefits (*e.g.*, eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan. The Employer has no authority or control over the funds deposited into an HSA.

ARTICLE XIII

Responsibilities of Participants

Each Participant shall be responsible for accurately reporting for tax purposes all taxable compensation received by him or her during each Plan Year. The Participant shall also be responsible for his or her portion of any additional income or Social Security taxes and for interest and penalties for the late payment of any taxes that may be owing in connection with any benefits paid under the Plan, and shall reimburse the Employer or Participating Employer for his or her portion of Social Security taxes and withholding taxes and for such interest and penalties, upon demand. Each Participant is responsible for the accuracy of all information and representations contained in any claim for benefits.

ARTICLE XIV

Administration and Fiduciary Provisions

14.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, unless the Employer appoints a replacement.

14.2 Plan Administration.

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary or desirable for the proper administration of the Plan;

(iv) To keep records of elections, claims and disbursements for claims under the Plan, and such other information as may be required by the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code or any other laws;

(x) To determine and announce any Benefit Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

(xii) To take such action as may be necessary to effect any required payroll deduction of any Benefit Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

14.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

14.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer or Participating Employer against all liabilities, costs and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer or Participating Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

14.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the Participants; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

14.6 Nondiscrimination Rules. If the Plan Administrator determines that there is non-compliance with any nondiscrimination rules required by the Internal Revenue Service, or non-compliance with the comparable contribution rules under Internal Revenue Code Section 4980G, the Plan Administrator may take action to ensure compliance. These actions may include modification of elections by highly compensated employees, key employees, or other participants, or modifications of Employer contribution amounts.

ARTICLE XV

Miscellaneous

15.1 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer or Participating Employer except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer or Participating Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

15.2 Communication to Employees. The Employer or Participating Employer will from time to time notify all Employees of the availability and terms of the Plan.

15.3 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Employer or Participating Employer. Nothing herein will be construed to require the Employer, Participating Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer or Participating Employer from which any payment under the Plan may be made.

15.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of Arizona, to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan shall be in any court of appropriate jurisdiction in the state of Arizona.

15.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

15.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

15.7 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of this Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

15.8 Expenses. All expenses incurred in establishing and operating the Plan, including, without limiting the generality of the foregoing, legal fees, accounting fees, administrative expenses and the like, shall be paid by the Employer or Participating Employer.

ARTICLE XVI

Participating Employers

16.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer's governing body.

16.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

16.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any flexible benefits program with respect to its Employees or former employees by resolution of its governing body.

ARTICLE XVII

Effective Date

This plan document sets forth the terms of the Plan as in effect July 01, 2019.

IN WITNESS WHEREOF, the Employer has caused this document to be duly executed in its name and on its behalf as of the date set forth below.

Mammoth-San Manuel Unified School District

By: _____
Date: _____

ATTEST:

_____

EXHIBIT A

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT
PREMIUM CONVERSION AND HEALTH SAVINGS ACCOUNT
CONTRIBUTION PLAN BENEFIT OPTIONS

The following Benefit Options are Welfare Programs which shall be treated as part of the Plan pursuant to Section 6.1 and as defined in Section 2.3:

Welfare Programs
Medical Plan

Carrier's or Benefit Option Administrator's Name:	Meritain Health
Contract Number:	13690
Address:	18444 N. 25th Ave, Suite 410 Phoenix, Arizona 85023 (602) 789-1170 http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Prescription Drug Plan

Carrier's or Benefit Option Administrator's Name:	Meritain Health
Contract Number:	13690
Address:	18444 N. 25th Ave, Suite 410 Phoenix, Arizona 85023 (602) 789-1170 http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Health Savings Account (HSA) Contributions

Carrier's or Benefit Option Administrator's Name:	Health Equity
Address:	15 W. Scenic Pointe Drive,, Suite 400 Draper, Utah 84020 (866) 346-5800 https://www.healthequity.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Dental Plan

Carrier's or Benefit Option Administrator's Name:	Sun Life Financial
Contract Number:	5463182
Address:	One Sun Life Executive Park Wellesley Hills, Massachusetts 02481 (800) 247-6875

http://www.sunlife.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Vision Plan

Carrier's or Benefit Option Administrator's Name:	Meritain Health
Contract Number:	13690
Address:	18444 N. 25th Ave, Suite 410 Phoenix, Arizona 85023 (602) 789-1170 http://www.meritain.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Life Insurance Plan

Carrier's or Benefit Option Administrator's Name:	Reliance Standard
Contract Number:	151487
Address:	4222 E. Thomas Rd., Suite 390 Phoenix, Arizona 85018 (602) 467-4700 http://www.reliancestandard.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Premium Conversion Plan

Carrier's or Benefit Option Administrator's Name:	Aflac
Address:	1932 Wynnton Road Columbus, Georgia 31999 (800) 992-3522 https://www.aflac.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

Any other Benefit Option(s) which the Employer may make available hereunder in accordance with Section 125(f) of the Code.

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT

PREMIUM CONVERSION AND HEALTH SAVINGS ACCOUNT CONTRIBUTION PLAN SUMMARY PLAN DESCRIPTION

Mammoth-San Manuel Unified School District
PO Box 406
San Manuel, Arizona 85631

V12072017

MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT
PREMIUM CONVERSION AND HEALTH SAVINGS ACCOUNT
CONTRIBUTION PLAN

SUMMARY PLAN DESCRIPTION

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MAMMOTH-SAN MANUEL UNIFIED SCHOOL DISTRICT
PREMIUM CONVERSION AND HEALTH SAVINGS ACCOUNT
CONTRIBUTION PLAN

SUMMARY PLAN DESCRIPTION

This summary plan description ("SPD") describes the Mammoth-San Manuel Unified School District Premium Conversion and Health Savings Account Contribution Plan (the "Plan"). Mammoth-San Manuel Unified School District (the "Employer") established the Plan to enable its employees to elect to reduce their compensation and make certain employee contributions on a pre-tax basis. This SPD explains how the Plan works, who administers it and the eligibility requirements. However, it is not the actual Plan. The actual Plan is a legal document which any employee may review and receive a copy upon request to the Plan Administrator. In the event of any conflict between any statements in this SPD and the provisions of the Plan, the provisions of the Plan will govern.

Plan records are maintained on the basis of the twelve-month period ending on June 30, which is called the "Plan Year."

Section 1. Purpose.

If you choose to participate in the Plan, you may elect to pay for one or more of the available "Benefit Options" (see Section 6 below), including contributions to a Health Savings Account ("HSA") (see Section 7 below), through pre-tax deductions from your compensation. Generally, the amount of your earnings that you elect to use to pay for your Benefit Options will not be subject to federal or state income tax or Social Security tax ("FICA").

The Plan is called a "Section 125 Plan" because, under Internal Revenue Code Section 125, it enables you to choose between cash compensation which is currently taxable to you and pre-tax contributions (within the limits permitted under the tax laws). You can decide which Benefit Options to choose. The Plan may also be referred to as a "cafeteria plan," which means that it is operated to give you a choice among pre-tax contributions (*e.g.*, for health care coverage) and after-tax cash compensation.

Section 2. How the Plan Works.

The Plan permits you to make pre-tax contributions to pay for certain "Benefit Options" for yourself and, if applicable, your spouse and eligible children. To use part of your cash compensation to purchase a Benefit Option under the Plan, you must complete and submit an election form required by the Plan Administrator, if you are not automatically enrolled. If required, the election form will indicate the Benefit Option or Benefit Options that you selected and the amount of money that will be deducted from your compensation to pay your share for those Benefit Options. The Employer deducts a pro-rated amount from each of your paychecks during the Plan Year.

Deducted amounts are credited to bookkeeping accounts maintained by the Employer in your name. Whenever you incur an expense which is covered by a Benefit Option you have elected, you must file a claim form in accordance with the procedures that apply to that Benefit Option.

Under current tax laws, amounts deducted from your cash compensation to purchase Benefit Options are generally not treated as taxable income. Therefore, when you use the Plan to pay for Benefit Options on a pre-tax, rather than on an after-tax basis, you should end up with more after-tax income to spend.

Contributions for coverage of eligible domestic partners are generally made on an after-tax basis.

Section 3. Eligible Employees.

All employees who are eligible for coverage under a Benefit Option are immediately eligible to participate in this Plan.

Section 4. How to Enroll in the Plan.

If you are not automatically enrolled in the Plan, you can enroll in the Plan by completing an election form for the Benefit Option(s) you have selected and filing the completed forms with the Plan Administrator on the date you first become eligible to enroll or during an open enrollment period before the beginning of the Plan Year. Coverage generally runs from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year and, with the exception of HSA contribution elections, cannot be changed or revoked unless you experience a "Change in Status" Event (described in Section 5 below).

Except for the Change in Status Events rule, there is no provision for stopping or starting payroll deductions or changing the amount of deductions at different times throughout the year. It is an IRS requirement that a pro-rated amount be deducted throughout the entire Plan Year. This limitation does not apply to contribution elections for HSAs.

Once you have enrolled in the Plan, again with the exception of HSA contributions, you will not need to complete another election form for any subsequent Plan Year to continue participation unless you want to revoke or modify your election.

If you cease to be a participant due to termination of employment and are rehired within 30 days, then your election that was in effect prior to your termination of employment shall be reinstated. If you are rehired more than 30 days following termination of employment, then you shall be treated as a new employee.

Section 5. Change in Status Events.

As explained in Section 4 above, with the exception of HSA contribution elections, your election must remain in effect from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year, unless you revoke or change your election due to a Change in Status Event. In accordance with IRS rules, when you experience a significant change in your status or your personal circumstances during a Plan Year that affects your need or eligibility for a Benefit Option, you can change your election by increasing or decreasing the amount you have deducted from your salary, or you may elect a Benefit Option or discontinue one. Any change you make must be consistent with the Change in Status Event. Examples of a Change in Status Event include the following:

(i) a change in your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;

(ii) a change in the number of your children, including due to the birth, adoption, placement for adoption, or death of a child;

(iii) a change in your employment status or your spouse's or covered child's change in employment, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage;

(v) you and/or your spouse or covered child has a change of residence; or

(vi) your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.

These are just some examples of Change in Status Events that may entitle you to make a change in your election during a Plan Year. Please consult the Plan Administrator for other circumstances that may be permissible Change in Status Events.

You must inform the Plan Administrator and make the change in your election within 30 days after the event that results in a Change in Status Event. If the Change in Status Event is the birth, adoption or placement for adoption of a child, then the effective date of the enrollment or change in election is the date of the child's birth, adoption or placement for adoption. If you do not inform the Plan Administrator of your need to make such a change within that 30-day period, you will then have to wait until the next open enrollment period to make a change in your election.

Please consult the Plan Administrator for additional information or if you have questions about Change in Status Events.

Section 6. Benefit Options Available Under the Plan.

Under the terms of the Plan, the Employer is authorized to offer you a salary reduction to pay for certain "Benefit Options" with pre-tax income as an alternative to cash compensation. These "Benefit Options" may change from time to time, depending on changes in the tax laws and other factors. The Benefit Options currently available to you under the Plan are as follows:

Medical Plan

Prescription Drug Plan

Dental Plan

Vision Plan

Life Insurance Plan

Other Plans – Other benefit plans may be added as Benefit Options in the future. If any other plans are added, you will receive written notice of the terms for participation in these plans.

Section 7. Health Savings Account Contributions.

An HSA is an account established under Section 223 of the Internal Revenue Code. If you are a "Health Savings Account-Eligible Individual" (see below), you may elect to make contributions to an HSA.

An HSA is not an Employer-sponsored benefit plan. It is an individual trust or custodial account separately established and maintained by a trustee or custodian outside of the Plan. Consequently, the HSA trustee or custodian, not the Employer, will establish and maintain the HSA.

Terms and conditions of coverage and benefits (*e.g.*, eligible medical expenses, claims procedures, etc.) will be provided by, and are set forth in, the HSA trust or custodial agreement provided by the applicable trustee or custodian to each electing Participant. The Employer has no authority or control over the funds deposited in an HSA.

A "Health Savings Account-Eligible Individual" means an individual (other than an individual who can be claimed as a tax dependent or who is entitled to Medicare) who has elected qualifying High Deductible Health Plan coverage and who has not elected any disqualifying non-High Deductible Health Plan coverage pursuant to Section 223(c) of the Internal Revenue Code. A "High Deductible Health Plan" is a health plan that meets the statutory limits for annual deductibles and out-of-pocket expenses for individual coverage or for family coverage, as defined in Section 223(c)(2) of the Internal Revenue Code. "Disqualifying

coverage" includes coverage under your spouse's medical insurance plan or a general purpose health care flexible spending account offered under the Employer's or your spouse's cafeteria plan.

You may not elect an HSA contribution if you are also covered by a general purpose health care flexible spending account. In addition, if you were covered by a general purpose health care flexible spending account for the prior Plan Year, you may be ineligible for HSA contributions if the health care flexible spending account has a grace period or carryover feature as part of its design.

An election to change an HSA contribution amount can be made at any time, and will generally be effective on the first day of the calendar month following the date of the election.

Your total annual contribution for HSA benefits must not exceed the statutory maximum amount for the calendar year in which the contribution is made. An additional catch-up contribution may be made if you are age 55 or older.

The statutory limits are indexed for inflation each year. The Plan Administrator will inform you of the dollar amounts relating to each of these statutory requirements for the current year.

In addition, the maximum annual contribution shall be reduced by the Employer contributions (if any) made on your behalf to the HSA.

The Employer, in its sole discretion, may make a contribution to your HSA in an amount to be determined by the Employer and communicated to you in a separate announcement. The Employer may change the timing or amount of, or eliminate entirely, its contribution at any time, and will notify you if it does so.

Section 8. Procedures for Claiming Benefits.

If you believe that you are not receiving credit for the proper contribution amount, you must file a written claim with the Plan Administrator setting forth the nature of the claim and the relief or correction sought. The Plan Administrator will respond to the claim within 90 days of its receipt (unless special circumstances require an extension). This procedure does not apply to Benefit Options available under the Plan. To file a written claim for benefits under one of the Benefit Options, you should refer to the summary plan description for such Benefit Option or contact the Plan Administrator.

If your claim is denied in whole or in part, you will receive a written notice from the Plan Administrator setting forth the specific reasons for the denial, specific reference to the pertinent provisions of the Plan on which the denial is based, a description of any additional material or information necessary for the claim to be approved, and a description of the claims review procedure under the Plan.

You are entitled to have the denial reviewed again by the Plan Administrator and, in connection with that review, you or your representative is entitled to examine all Plan documents

and submit issues and comments in writing. If you want the Plan Administrator to review the denial, you must inform the Plan Administrator in writing within 60 days after you receive the Plan Administrator's notice of denial. The Plan Administrator will inform you in writing of the final decision and the specific reasons for that decision within 60 days of your request for review (unless special circumstances justify a delay).

Section 9. Plan Amendment or Termination.

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Benefit Options. However, all previous salary deductions will be used to pay for Benefit Options.

Section 10. Miscellaneous Information.

Type of Plan:	The Plan is a cafeteria plan intended to qualify under Section 125 of the Internal Revenue Code.
Plan Year:	The Plan Year is the twelve month period ending June 30.
Plan Sponsor:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337
Plan Sponsor's Identification Number:	86-6000557
Plan Administrator:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337
Agent for Service of Legal Process:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337 Service of legal process may also be made upon the Plan Administrator.
For Questions Please Call:	Mammoth-San Manuel Unified School District PO Box 406 San Manuel, Arizona 85631 (520) 385-2337