

Table of Contents Insight CCS Renewal Part 5

<u>Section</u>	<u>Page #'s</u>
2.2-4	2-543
2.2-5	544-593
2.2-6	594-635
2.3-2	636-687
2.3-3	688-721
2.3-4	722-740



Insight PA Cyber Charter School

Benefits Packages

Table of Contents:

1. One America Life Insurance
2. One America Short Term Disability 1
3. One America Short Term Disability 2
4. Transamerica Accident Insurance
5. Transamerica Critical Illness Insurance
6. Transamerica Hospital Indemnity
7. Independence Blue Cross Medical
8. IBX PPO Plan
9. Metlife Dental
10. Eyemed Vision



American United Life Insurance Company®
Indianapolis, Indiana 46206-0368

Certifies that it has issued and delivered a Policy numbered G 2535(T) E to:

Fifth Third Bank, Indiana, Trustee For
The American United Life Group Insurance Trust
For The Business And Professional Service Industry
(Hereinafter called the Group Policyholder)

Insight Pennsylvania Cyber Charter School

shall participate in the coverage as a Participating Unit.

Participating Unit Number: G 00618131-0000-000 Class: 001
Change Effective Date: Does Not Apply

This certificate replaces any and all certificates previously issued to You under the Policy indicated above.

American United Life Insurance Company® (AUL) certifies that the Employee whose enrollment form is on file with the Participating Unit as being eligible for insurance and for whom the required premium has been paid is insured under the Policy named above for group insurance benefits as designated in the Schedule of Benefits. Benefits are subject to change as described on the Schedule of Benefits page.

This certificate describes the coverage provided in the Policy. The Policy determines all rights and benefits in this certificate and may be amended, cancelled, or discontinued at any time by agreement between AUL and the Participating Unit without notice to You. The Policy may be examined at the main office of AUL during regular office hours.

If an Employee is not Actively At Work on the date insurance would otherwise become effective, the individual Effective Date is the date the Employee returns to full-time Active Work.

Thomas M. Zurek
Secretary

J. Scott Davison
Chairman, President and Chief Executive Officer

**CERTIFICATE OF INSURANCE
GROUP VOLUNTARY TERM LIFE INSURANCE CERTIFICATE
WITH AN ACCELERATED LIFE BENEFIT**

THE DEATH BENEFIT WILL BE REDUCED IF THE ACCELERATED LIFE BENEFIT IS PAID

**NOTE: RECEIPT OF THE ACCELERATED LIFE BENEFIT MAY BE TAXABLE.
PLEASE SEEK ASSISTANCE FROM A PERSONAL TAX ADVISOR.**

TABLE OF CONTENTS

	SECTION
PROVISIONS	
Schedule of Benefits	1
Definitions	2
Eligibility, Enrollment, and Individual Effective Date	3
Continuity of Coverage	5
Changes in Insurance Coverage	6
Continuation of Insurance	7
Portability	7A
Waiver of Premium	8
Individual Terminations	9
Conversion Privilege	10
Individual Reinstatements	11
Accelerated Life Benefit	13
Suicide Limitation	14
Payment of Death Benefits	15
Naming of Beneficiary	16
The Death Claim	17
Determination of Death Benefit Payee	18
Selection of Payment Method	19

TABLE OF CONTENTS
(Continued)

PROVISIONS	SECTION
Dependent Insurance	20
Eligibility	20A
Individual Effective Date	20B
Changes in Insurance Coverage	20C
Individual Terminations	20E
Conversion Privilege	20F
Dependent Spouse Accelerated Life Benefit	20H
Suicide Limitation	20I
Payment of Death Benefits	20J
Dependent Termination	20K
 General Policy Provisions	 21
 Premium Payment	 22
 Insured Units	 23
 Termination of the Policy	 24
 Termination of a Participating Unit	 25
 Termination of a Portable	 26

SECTION 1 - SCHEDULE OF BENEFITS

This coverage is only offered to You if the required premiums are paid timely and if:

- 1) the coverage was requested in the application signed by the Participating Unit and approved by AUL;*
- 2) You requested the coverage on an application form approved by AUL; and*
- 3) AUL determines in its discretion or judgment all other terms, conditions, and requirements outlined in this insurance contract have been met.*

CLASS: 001

CLASSIFICATION: All Full-Time Eligible Employees

LIFE AMOUNT:

The Life Amount is a flat amount available in \$10,000 increments. The minimum Life Amount is \$10,000. The maximum Life Amount is \$500,000, or five times the Employee's Annual Base Salary, then rounded up to the next \$10,000 whichever is less.

ACCELERATED LIFE BENEFIT (ALB):

You may request payment of 25%, 50%, or 75% of the Life Amount. This benefit is available on Life Amounts of \$10,000 or more. The maximum payment is limited to 25%, 50%, or 75% of the Life Amount shown; however, AUL will not issue an amount less than \$2,500. See Section 13. There is no additional premium charged for this benefit.

ANNUAL BASE SALARY: Annual Base Salary Only. See Section 2.

CHANGES IN INSURANCE COVERAGE: First of the Month. See Section 6.

CONTRIBUTIONS: Employee premium contributions are required. See Section 2.

ELIGIBILITY: First of the Month. See Section 3.

FULL-TIME EMPLOYEE REQUIREMENT: 30 hours or more per week. See Section 2.

GUARANTEED INCREASE IN BENEFIT (GIB): This benefit is included. See Section 6.

SECTION 1 - SCHEDULE OF BENEFITS
(Continued)

GUARANTEED ISSUE AMOUNT (GIA): The Guaranteed Issue Amount is \$150,000.

Any amount of coverage for which You request greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 3.

INDIVIDUAL EFFECTIVE DATE: First of the Month. See Section 3.

INDIVIDUAL REINSTATEMENTS: First of the Month. See Section 11.

INDIVIDUAL TERMINATIONS: Immediate. See Section 9.

INITIAL ENROLLMENT PERIOD

Present Employees: Between 11/15/2018 and 12/31/2018. See Section 3.

New Employees: 31 days following the Employees Eligibility Date. See Section 3.

REDUCTIONS: Reduction Schedule changes due to age will be effective on the Participating Unit's Anniversary Date following the date the Employee reaches certain ages as follows:
Upon attainment of age 70, the Life Amount will reduce by 50%.

Reductions will be based upon the Life Amount prior to the payment of any Accelerated Life Benefit.

SUICIDE LIMITATION: This limitation is included. See Section 14.

TERMINATIONS: Terminations are governed by the Individual Terminations Section. See Section 9.

WAITING PERIOD for Present Employees hired before the Participating Unit's effective date: First of the Month following 0 days. See Eligibility, Section 3.

WAITING PERIOD for New Employees hired on or after the Participating Unit's effective date: First of the Month following 0 days. Also, see Eligibility, Section 3.

WAIVER OF PREMIUM FOR TOTAL DISABILITY: This benefit is included. Reductions are applicable to this benefit. See Section 8.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE**

This coverage is only offered to Your Dependent if the required premiums are paid timely and if:

- 1) *the coverage was requested in the application signed by the Participating Unit and approved by AUL;*
- 2) *You requested the coverage on an application form approved by AUL; and*
- 3) *AUL determines in its discretion or judgment all other terms, conditions, and requirements outlined in this insurance contract have been met.*

Class 001, Option 01

SPOUSE under age 70:

LIFE AMOUNT: The Dependent Life Amount is a flat dollar amount purchased in \$500 increments. The minimum Life Amount is \$10,000. The maximum Life Amount is \$20,000. The Dependent Life Amount is limited to 100% of the Employee's Life Amount.

GUARANTEED ISSUE AMOUNT FOR DEPENDENT SPOUSE: \$20,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD live birth to under 6 months:

LIFE AMOUNT: \$1,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (live birth to under 6 months): \$1,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD 6 months to under 26 years or under age 26 if a full-time student:

LIFE AMOUNT: \$2,500

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (6 months to under 26 years or under age 26 if a full-time student): \$2,500

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE
(Continued)**

Class 001, Option 01

DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT:

You may apply to receive payment of 50% or 75% of the Dependent Spouse Life Amount. This benefit is available on a Dependent Spouse Life Amount of \$5,000 or more. The maximum payment is limited to 75% of the Dependent spouse Life Amount shown; however, AUL will not approve a payment amount less than \$2,500. See Section 20H, Accelerated Life Benefit for Dependent spouse. There is no additional premium charged for this benefit.

Reductions will be based upon the Dependent Life Amount prior to the payment of any Accelerated Life Benefit for Dependent Spouse.

SUICIDE LIMITATION: This limitation is included in a Dependent's insurance coverage. See Section 20I.

TERMINATIONS: Terminations are governed by the Dependent Individual Terminations section of the policy. See Section 20E.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE**

This coverage is only offered to Your Dependent if the required premiums are paid timely and if:

- 1) *the coverage was requested in the application signed by the Participating Unit and approved by AUL;*
- 2) *You requested the coverage on an application form approved by AUL; and*
- 3) *AUL determines in its discretion or judgment all other terms, conditions, and requirements outlined in this insurance contract have been met.*

Class 001, Option 02

SPOUSE under age 70:

LIFE AMOUNT: The Dependent Life Amount is a flat dollar amount purchased in \$500 increments. The minimum Life Amount is \$10,000. The maximum Life Amount is \$20,000. The Dependent Life Amount is limited to 100% of the Employee's Life Amount.

GUARANTEED ISSUE AMOUNT FOR DEPENDENT SPOUSE: \$20,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD live birth to under 6 months:

LIFE AMOUNT: \$1,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (live birth to under 6 months): \$1,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD 6 months to under 26 years or under age 26 if a full-time student:

LIFE AMOUNT: \$5,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (6 months to under 26 years or under age 26 if a full-time student): \$5,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE
(Continued)**

Class 001, Option 02

DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT:

You may apply to receive payment of 50% or 75% of the Dependent Spouse Life Amount. This benefit is available on a Dependent Spouse Life Amount of \$5,000 or more. The maximum payment is limited to 75% of the Dependent spouse Life Amount shown; however, AUL will not approve a payment amount less than \$2,500. See Section 20H, Accelerated Life Benefit for Dependent spouse. There is no additional premium charged for this benefit.

Reductions will be based upon the Dependent Life Amount prior to the payment of any Accelerated Life Benefit for Dependent Spouse.

SUICIDE LIMITATION: This limitation is included in a Dependent's insurance coverage. See Section 20I.

TERMINATIONS: Terminations are governed by the Dependent Individual Terminations section of the policy. See Section 20E.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE**

This coverage is only offered to Your Dependent if the required premiums are paid timely and if:

- 1) *the coverage was requested in the application signed by the Participating Unit and approved by AUL;*
- 2) *You requested the coverage on an application form approved by AUL; and*
- 3) *AUL determines in its discretion or judgment all other terms, conditions, and requirements outlined in this insurance contract have been met.*

Class 001, Option 03

SPOUSE under age 70:

LIFE AMOUNT: The Dependent Life Amount is a flat dollar amount purchased in \$500 increments. The minimum Life Amount is \$10,000. The maximum Life Amount is \$20,000. The Dependent Life Amount is limited to 100% of the Employee's Life Amount.

GUARANTEED ISSUE AMOUNT FOR DEPENDENT SPOUSE: \$20,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD live birth to under 6 months:

LIFE AMOUNT: \$1,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (live birth to under 6 months): \$1,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD 6 months to under 26 years or under age 26 if a full-time student:

LIFE AMOUNT: \$7,500

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (6 months to under 26 years or under age 26 if a full-time student): \$7,500

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE
(Continued)**

Class 001, Option 03

DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT:

You may apply to receive payment of 50% or 75% of the Dependent Spouse Life Amount. This benefit is available on a Dependent Spouse Life Amount of \$5,000 or more. The maximum payment is limited to 75% of the Dependent spouse Life Amount shown; however, AUL will not approve a payment amount less than \$2,500. See Section 20H, Accelerated Life Benefit for Dependent spouse. There is no additional premium charged for this benefit.

Reductions will be based upon the Dependent Life Amount prior to the payment of any Accelerated Life Benefit for Dependent Spouse.

SUICIDE LIMITATION: This limitation is included in a Dependent's insurance coverage. See Section 20I.

TERMINATIONS: Terminations are governed by the Dependent Individual Terminations section of the policy. See Section 20E.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE**

This coverage is only offered to Your Dependent if the required premiums are paid timely and if:

- 1) *the coverage was requested in the application signed by the Participating Unit and approved by AUL;*
- 2) *You requested the coverage on an application form approved by AUL; and*
- 3) *AUL determines in its discretion or judgment all other terms, conditions, and requirements outlined in this insurance contract have been met.*

Class 001, Option 04

SPOUSE under age 70:

LIFE AMOUNT: The Dependent Life Amount is a flat dollar amount purchased in \$500 increments. The minimum Life Amount is \$10,000. The maximum Life Amount is \$20,000. The Dependent Life Amount is limited to 100% of the Employee's Life Amount.

GUARANTEED ISSUE AMOUNT FOR DEPENDENT SPOUSE: \$20,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD live birth to under 6 months:

LIFE AMOUNT: \$1,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (live birth to under 6 months): \$1,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

CHILD 6 months to under 26 years or under age 26 if a full-time student:

LIFE AMOUNT: \$10,000

GUARANTEED ISSUE AMOUNT FOR DEPENDENT CHILD (6 months to under 26 years or under age 26 if a full-time student): \$10,000

Any amount of coverage for which the Dependent requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 20C.

**SECTION 1 - SCHEDULE OF BENEFITS
DEPENDENT INSURANCE
(Continued)**

Class 001, Option 04

DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT:

You may apply to receive payment of 50% or 75% of the Dependent Spouse Life Amount. This benefit is available on a Dependent Spouse Life Amount of \$5,000 or more. The maximum payment is limited to 75% of the Dependent spouse Life Amount shown; however, AUL will not approve a payment amount less than \$2,500. See Section 20H, Accelerated Life Benefit for Dependent spouse. There is no additional premium charged for this benefit.

Reductions will be based upon the Dependent Life Amount prior to the payment of any Accelerated Life Benefit for Dependent Spouse.

SUICIDE LIMITATION: This limitation is included in a Dependent's insurance coverage. See Section 20I.

TERMINATIONS: Terminations are governed by the Dependent Individual Terminations section of the policy. See Section 20E.

SECTION 2 - DEFINITIONS

ACCIDENTAL BODILY INJURY means an injury occurring, either directly or indirectly, as a result of an accident, along with all other related conditions, sustained by an individual while insured under the policy.

ACTIVE PAY STATUS means You are eligible to and receiving pay from the Participating Unit, and includes, but is not limited to, vacation leave, sick leave, bereavement leave, administrative leave, compensatory time, holidays, and personal leave.

ACTIVE WORK and ACTIVELY AT WORK mean the use of time, services, and energy by You for the Participating Unit at the Participating Unit's regular place of business, an alternate location approved by the Participating Unit, or an alternate location to which the Participating Unit requires You to travel. You must be physically and mentally capable of performing each of the material and substantial duties of Your regular position with the Participating Unit for at least the minimum number of hours listed in the Schedule of Benefits under the Full Time Employee Requirement. Active Work will include time off for vacation, jury duty, paid holidays, and funeral leave approved by the Participating Unit when You could have been Actively at Work. When You are in Active Pay Status You will be considered Actively at Work. Active Work does not include periods of time when You are not Actively at Work following an injury, Accidental Bodily Injury, Sickness, strike, lock-out, or layoff, unless You are in Active Pay Status.

ANNUAL BASE SALARY means Your yearly gross wages received from the Participating Unit based on a maximum forty (40) hour work week. Annual Base Salary is based on the amount last reported in writing to AUL by the Participating Unit and approved for coverage under the Policy by AUL before the date of death or the events shown in the AD&D provisions if AD&D coverage is included. Annual Base Salary does not include amounts received from commissions, bonuses, overtime or reimbursement for expenses.

SECTION 2 - DEFINITIONS
(Continued)

BASIC LIVING EXPENSES include the cost of food, shelter, clothing and any other basic living expenses of the average American household. Each household member need not contribute equally or jointly to the payment of these expenses as long as each agrees both are responsible for the basic living expenses.

BI-WEEKLY means every two weeks or 26 times a year.

CHILD means any minor related by blood, marriage or court order that can be claimed as a dependent for federal income tax purposes, and may include:

- 1) any of Your natural born child(ren);
- 2) any of Your legally adopted child(ren) from the time of placement in Your home and the filing of documents with the court to adopt;
- 3) any stepchild(ren) who live with You;
- 4) any child(ren) for whom You have legal guardianship; or
- 5) any children for whom coverage must be provided in accordance with state law or court order.

CONTINUATION UNIT means any person who has been approved for Continuation of Insurance. See Section 7, Continuation of Insurance.

CONTRIBUTORY INSURANCE means insurance for which You pay part or all of the premium.

COVERAGE MONTH means that period of time beginning on the first day that the Participating Unit's coverage is in force, as shown in the Participating Unit's Subscription Agreement, and ending on the day before that date of the next month.

DATE OF DISABILITY means the first day You are not Actively at Work due to an Accidental Bodily Injury or Sickness and results in Total Disability.

SECTION 2 - DEFINITIONS
(Continued)

DEPENDENT means:

- 1) Your legal spouse under age 70;
- 2) Your Domestic Partner under age 70 whose relationship with You is recognized by and allowed under applicable state law provided both the Domestic Partner and You;
 - a) share the same regular and permanent residence;
 - b) have a close personal relationship similar to lawful marriage;
 - c) have agreed to be jointly responsible for Basic Living Expenses, incurred during the domestic partnership;
 - d) are not married to anyone;
 - e) are 18 years of age and older;
 - f) are not so closely related by blood to be prohibited under applicable state laws;
 - g) were mentally competent to consent to a contract when the domestic partnership began;
 - h) are each other's sole domestic partner; and
 - i) are responsible for each other's welfare;
- 3) Your unmarried Child from live birth and under the age of 26, if the Child:
 - a) is not eligible under the policy for Personal Insurance;
 - b) is not in the military of any country; and
 - c) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return;
- 4) Your unmarried Child under the age of 26 if the Child:
 - a) is registered at and attending an accredited educational institution on a full-time basis as defined by the regulations of the institution, and
 - b) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return; and
- 5) Your unmarried Child who is disabled and incapable of self-sustaining employment as a result of mental or physical disability. The Child must have been disabled prior to age 26. If the Child is at least age 26 on Your effective date, coverage is subject to AUL's receiving written proof of the disability on that date including but not limited to receipt of Social Security Administration disability benefits. If the Child is not at least age 26 extension of coverage is subject to AUL's receiving written proof of the disability not later than 120 days after the Child attains age 26. Proof of continued disability shall be required not more than once each year thereafter.

DEPENDENT INSURANCE means the insurance provided under the policy covering Your Dependents, Section 20 if included in the policy.

ELIMINATION PERIOD see Waiver of Premium, Section 8, if shown in the Subscription Agreement.

ELIGIBLE UNIT means any entity which is a subsidiary of or under majority ownership of the Participating Unit.

SECTION 2 - DEFINITIONS
(Continued)

EMPLOYEE means any individual who is a full-time, permanent Employee (including owner, member, partner, or shareholder) of the Participating Unit:

- 1) who is legally authorized to work and reside in the United States under applicable state and federal laws; and
- 2) whose employment with the Participating Unit constitutes his principal occupation; and
- 3) who regularly works at that occupation at the Participating Unit's regular place of business a minimum of 30 hours or more per week; and
- 4) who is not temporarily or seasonally employed by the Participating Unit; and
- 5) who is an employee, participant, person, or any member of any employee organization, who is or may become eligible to receive a benefit of any type from the Participating Unit's employee welfare benefit plan; and
- 6) who is not an independent contractor.

EMPLOYEE also means an individual designated by the Participating Unit and shown in the Subscription Agreement.

EMPLOYEE also means Retiree and Grandfathered Retiree. See Section 4, Retirees.

EMPLOYER see PARTICIPATING UNIT.

EVIDENCE OF INSURABILITY means a signed statement of proof acceptable to AUL of a person's medical history provided at no expense to AUL, and, if requested by AUL, medical records, tests, and/or examinations at no expense to AUL. Satisfactory Evidence of Insurability must include information and documentation, which can be used by AUL to determine if the individual is an acceptable underwriting risk and can be approved for coverage under AUL's guidelines.

GRANDFATHERED RETIREE, see Retirees, Section 4, if shown in the Subscription Agreement.

GUARANTEED ISSUE AMOUNT means the amount of coverage that does not require Evidence of Insurability. This amount is selected by the Participating Unit, shown in the Subscription Agreement, and approved in writing by AUL.

SECTION 2 - DEFINITIONS
(Continued)

INSURED UNIT means any Eligible Unit shown in the Subscription Agreement and is insured under the policy. See Section 23.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the most recent version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association as of the date of Total Disability and has been diagnosed by a Physician. Such disorders include, but are not limited to, psychotic, emotional, behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, Mental Illness will be determined based on the diagnostic manual then published by the American Psychiatric Association on the date of Total Disability.

NON-CONTRIBUTORY INSURANCE means insurance for which You pay no portion of the premium.

PARTICIPATING UNIT means the entity which applied for and was approved by AUL for coverage. Any references to Participating Unit used in the policy shall include Insured Units.

A Participating Unit is eligible for coverage under the policy as determined by AUL. In order for the Participating Unit to remain eligible for coverage under the policy, participation must be not less than 10 insured's in each Participating Unit.

PARTICIPATING UNIT'S ANNIVERSARY DATE means the date once a year which marks when the Participating Unit became insured under the policy.

PERMANENT AND TOTAL DISABILITY/PERMANENTLY AND TOTALLY DISABLED means Your inability as determined by a Physician to engage, due to Accidental Bodily Injury or Sickness in any occupation for which You are fitted by training, education or experience. Permanent and Total Disability/Permanently and Totally Disabled must occur after You become insured under the policy and it must be conclusively determined the Permanent And Total Disability will continue for Your lifetime.

PERSONAL INSURANCE means the insurance provided under the policy for You.

PHYSICIAN means a qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be licensed prior to engaging in the practice of medicine and who is, practicing within the scope of his specialty, license, and applicable law. Physician does not include any medical provider affiliated with the Participating Unit, or anyone related by blood, marriage, or domestic partnership to an Employee.

POLICY MONTH means that period of time the policy is in force beginning on the first day of a calendar month, as shown in the Title Page, and ending on the last day of that calendar month.

PORTABLE means any Employee who has been approved for and is receiving benefits under the Portability provisions. See Section 7A, Portability.

REGULAR ATTENDANCE means that You or Your Dependent:

- 1) are receiving periodic medical treatment and services from a Physician when medically required and according to standard medical protocol to effectively manage and treat You or Your Dependent's Disability;
- 2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in Your return to work; and
- 3) is receiving medical care and services from a Physician whose specialty or practice is related to the Disability.

SECTION 2 - DEFINITIONS
(Continued)

RETIREE means an individual who, on his last day of Active Work prior to retirement, was an Actively at Work Employee and who is receiving benefits under the Participating Unit's retirement plan. Retiree does not include an Employee who is receiving benefits under his retirement plan solely due to being Totally Disabled and who otherwise does not meet the Participating Unit's retirement plan's criteria for receipt of benefits, see Retirees, Section 4, if shown in the Subscription Agreement.

SICKNESS means illness, bodily disorder or disease, Mental Illness, normal pregnancy and complications of pregnancy. Complication of Pregnancy is defined as concurrent disease or abnormal conditions significantly affecting the usual medical management of pregnancy.

SUBSCRIPTION AGREEMENT means the applications for insurance executed by the Participating Unit and approved in writing by AUL.

TEMPORARY LAY-OFF means a period of time during which You are not Actively at Work due to lack of work and are not terminated from employment with the Participating Unit.

TOTAL DISABILITY AND TOTALLY DISABLED mean that because of Accidental Bodily Injury or Sickness You cannot engage in any occupation for which You are reasonably fitted by training, education, or experience. If you accept any type of employment, other than in a state-approved rehabilitation program or sheltered workshop, You will be considered fitted to that occupation.

WE, OUR, US, and AUL mean American United Life Insurance Company®.

YOU and YOUR, when used in the policy's certificate of insurance, has the same meaning as Employee.

**SECTION 3 - ELIGIBILITY, ENROLLMENT,
AND INDIVIDUAL EFFECTIVE DATE**

DEFINITIONS

INITIAL ENROLLMENT PERIOD means either of the periods during which You may first make written application for coverage under the policy and includes:

- 1) For a Present Employee, the Initial Enrollment Period is shown on the Schedule of Benefits under INITIAL ENROLLMENT PERIOD.
- 2) For a New Employee, the Initial Enrollment Period is:
 - a) the period ending on the number of days selected by the Participating Unit and as shown on the Schedule of Benefits under INITIAL ENROLLMENT PERIOD after the date the Employee becomes eligible for coverage under the policy; or
 - b) the next Scheduled Enrollment Period after the date the Employee becomes eligible for coverage under the policy.

LATE ENROLLEE means a Present or New Employee who did not request coverage during his Initial Enrollment Period.

NEW EMPLOYEE means an Employee who is employed by the Participating Unit on or after the Participating Unit's Effective Date.

PRESENT EMPLOYEE means an Employee who is employed by the Participating Unit before the Participating Unit's Effective Date.

SCHEDULED ENROLLMENT PERIOD means period of days shown in the Subscription Agreement after the Participating Unit's Effective Date, during which an Employee may apply to become covered under the policy, or during which an Employee may apply to change his coverage amounts. This period must be approved in writing by AUL.

WAITING PERIOD means the period of days beginning on the Employee's hire date that an Employee must be continuously Actively at Work prior to becoming eligible for Personal Insurance. Present Employees will be given credit for time insured under the Participating Unit's prior group life insurance contract if the policy replaces the same coverage available under the prior group life insurance contract. The Waiting Period is shown in the Subscription Agreement.

**SECTION 3 - ELIGIBILITY, ENROLLMENT, AND INDIVIDUAL EFFECTIVE DATE
(Continued)**

ELIGIBILITY OF EMPLOYEE

On the effective date of the policy, a Present Employee becomes eligible for Personal Insurance if:

- 1) the Employee has fulfilled the Waiting Period, if any, and is Actively at Work;
- 2) the Employee has fulfilled the Waiting Period, if any, and is not Actively at Work due to being on an Employer-approved leave of absence other than for injury or Sickness; or
- 3) the Employee has fulfilled the Waiting Period, if any, and is not Actively at Work due to being on Temporary Lay-off.

A New Employee becomes eligible for Personal Insurance on the first day of the second month following the Date of Hire; or on the next Scheduled Enrollment Period beginning on or following the date the Employee becomes eligible.

ENROLLMENT

Any eligible Employee, prior to receiving coverage under the policy, must make written request for coverage under the policy to AUL on a form approved by AUL and must make timely contributions of the required amount of premium to AUL. An eligible Employee may request coverage only during an Initial or Scheduled Enrollment Period as follows:

- 1) During an Employee's Initial Enrollment Period, an Employee may request coverage under the policy.
- 2) During an Employee's Scheduled Enrollment Period:
 - a) If an Employee did not request coverage during his Initial Enrollment Period, he will be considered a Late Enrollee. Enrollment at a later date can only be conducted during a Scheduled Enrollment Period. Satisfactory Evidence of Insurability will be required before any coverage will be approved by AUL.
 - b) An Employee may apply to increase his Life Amount with satisfactory Evidence of Insurability. See Section 6, Changes in Insurance Coverage.

CHANGE IN FAMILY STATUS

Family Status Change means:

- 1) Marriage or divorce;
- 2) Birth or adoption of a child, or becoming the legal guardian of a child;
- 3) Death of a spouse;
- 4) Death of a child; or
- 5) A change in the Employee's spouse's employment status that affects eligibility for benefits.

If the Employee has a change in Family Status, he may enroll for Employee coverage and for dependent coverage for the first time within 31 days of the family status event without Evidence of Insurability, subject to the Guaranteed Issue Amount for employees and subject to the Guaranteed Issue Amount for dependents. If the Employee has a change in Family Status, he may increase coverage in the amount of \$10,000 without providing Evidence of Insurability, subject to the Guaranteed Issue Amount. Any increase in dependent spouse coverage requires Evidence of Insurability. To be eligible for coverage under the change in Family Status provision, the Employee must:

- 1) Make written application within 31 days of the change in Family Status;
- 2) Pay the required premium, if applicable; and
- 3) Provide any required proof of the change in Family Status required by AUL.

For increases following a Family Status Change, the coverage will be effective on the First of the Month occurring on or after the later of the date of the request or the date of our correspondence notifying the Employee of our approval of satisfactory Evidence of Insurability.

SECTION 3-ELIGIBILITY, ENROLLMENT, AND INDIVIDUAL EFFECTIVE DATE

**SECTION 3 - ELIGIBILITY, ENROLLMENT,
AND INDIVIDUAL EFFECTIVE DATE
(Continued)**

INDIVIDUAL EFFECTIVE DATE OF INSURANCE

Present Employee

For an eligible Present Employee the Individual Effective Date of Insurance will be the Participating Unit's Effective Date.

New Employee

Coverage will be effective on the first day of the Coverage Month following the Waiting Period for an eligible New Employee, the Individual Effective Date of Insurance for coverage requested during the Initial Enrollment Period, the Individual Effective Date will be:

- 1) the date of the request, if that date is the first day of a Coverage Month; or
- 2) the first day of the next Coverage Month, if the request is made after the first day of a Coverage Month.

If an Employee is not Actively At Work on the date insurance would otherwise become effective, the Individual Effective Date is the date the Employee returns to full-time Active Work.

LATE ENROLLEES

FOR COVERAGE REQUESTED BY A LATE ENROLLEE DURING A SCHEDULED ENROLLMENT PERIOD, SATISFACTORY EVIDENCE OF INSURABILITY WITHOUT EXPENSE TO AUL IS REQUIRED AND THE INDIVIDUAL EFFECTIVE DATE OF INSURANCE WILL BE IDENTIFIED BY AUL.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required if:

- 1) request is made by a Late Enrollee;
- 2) request is made after a termination of insurance due to failure to pay the required amount of premium timely;
- 3) the amount requested by the Employee during the Initial Enrollment Period exceeds the Guaranteed Issue Amount shown in the Schedule of Benefits; or
- 4) the Employee requests an increase in coverage not allowed under the Guaranteed Increase Benefit.

Any amount of coverage for which the Employee requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. If an amount greater than the Guaranteed Issue Amount is not approved by AUL, the Life Amount will be equal to the Guaranteed Issue Amount and will be effective as set forth above.

SECTION 5 - CONTINUITY OF COVERAGE

References to Dependent used in this section apply only if the Participating Unit's coverage under the policy includes Dependent Insurance.

Coverage will be extended under this section to an Employee or Employee's Dependent who:

- 1) was insured under the prior carrier's group term life insurance on its termination date; but
- 2) was not eligible for coverage on the effective date of the Participating Unit's coverage under the policy because:
 - a) in the case of an Employee, he was not Actively at Work; or
 - b) in the case of a Dependent, was confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility.

Coverage may be extended if such Employee or Dependent:

- 1) applies to AUL for coverage on or before the effective date of the Participating Unit's coverage under the policy;
- 2) pays the required amount of premium; and
- 3) is not eligible to continue coverage under the prior carrier's group term life insurance.

The amount of coverage extended will be the lesser of:

- 1) the coverage for which the Employee or Dependent would have been eligible to receive under the policy, if the Employee had been Actively at Work or the Dependent had not been confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility; or
- 2) the coverage the Employee or Dependent received under the Participating Unit's prior carrier's group term life insurance policy minus the amount payable under that group term life policy.

The coverage under this section will terminate on the earliest of the following dates:

- 1) the date for which any required premium was not received by AUL;
- 2) the date the Personal Insurance or Dependent Insurance becomes effective under the Participating Unit's coverage under the policy;
- 3) the date the coverage would have terminated under the Individual or Dependent Termination Sections of the Participating Unit's coverage under the policy if the Personal Insurance or Dependent Insurance had become effective; or
- 4) the date the Employee or Dependent becomes eligible for coverage under the prior carrier's group term life insurance policy.

This coverage only includes the Life Amount.

SECTION 6 - CHANGES IN INSURANCE COVERAGE

GUARANTEED INCREASE IN BENEFIT (GIB)

You may request an additional amount of coverage (also known as GIB) at each AUL approved Scheduled Enrollment Period without satisfactory Evidence of Insurability, if the following conditions are met:

- 1) You must be under age 70;
- 2) You must be Actively at Work on the effective date of the increase;
- 3) the amount of each increase will be the GREATER of:
 - a) 10% of Your coverage rounded up to the next \$1,000; or
 - b) \$10,000;
- 4) the amount of coverage after the increase is not greater than the maximum amount of coverage available to You; and
- 5) an Accelerated Life Benefit has not been paid.

If there is an age reduction schedule and reductions begin prior to age 70, the GIB offered will be based on the reduced amount of coverage and Your attained age. In no event will the total amount of coverage including any GIB increases exceed the maximum Life Amount shown in the Schedule of Benefits, or five (5) times, or other function of Your Annual Base Salary.

Any increase in Dependent Insurance can occur when Your GIB increases the Life Amount and the Dependent Insurance is a percentage of Your Life Amount.

If You decline coverage during the Initial Enrollment Period and want to enroll at a later Scheduled Enrollment date, receipt of any coverage will first require Evidence of Insurability and information satisfactory to AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage is approved, coverage will begin on the date identified in writing by AUL. If You are approved for coverage during the Scheduled Enrollment, You will be eligible to request the GIB at the next Scheduled Enrollment Period.

If coverage for You is declined following unsatisfactory Evidence of Insurability, no GIB will be available until Evidence of Insurability and information satisfactory to AUL is received. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If the GIB request is approved, coverage will begin on the date identified in writing by AUL.

COVERAGE AMOUNTS REQUESTED IN EXCESS OF THE GUARANTEED INCREASE IN BENEFIT

During Scheduled Enrollment Periods, You may apply to increase coverage above the GIB, however, receipt of any coverage above the GIB will first require Evidence of Insurability and information satisfactory to AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage is approved, coverage will begin on the date identified in writing by AUL.

If coverage for You is declined following unsatisfactory Evidence of Insurability, no GIB will be available until Evidence of Insurability and information satisfactory to AUL is received. Until the GIB is approved, only the amount previously approved by AUL will be available.

SECTION 6 - CHANGES IN INSURANCE COVERAGE
(Continued)

EFFECTIVE DATE OF CHANGE

The amount of coverage for which You are eligible is shown in the Schedule of Benefits.

A change in coverage that does not increase the amount of coverage becomes effective the earlier of:

- 1) the first day of the Coverage Month following any scheduled reduction;
- 2) the first day of the Coverage Month following AUL's written approval of the change, if the date is the first day of the Coverage Month; or
- 3) the first day of the next Coverage Month following AUL's written approval of the change, if the date is after the first day of the Coverage Month.

Prior to a change in coverage that increases the amount of coverage, the Employee must be Actively at Work and the required amount of premium must be paid.

A change increasing the amount of coverage equal to or less than Your GIB offer takes effect on:

- 1) the first day of the Coverage Month; if You become eligible for the change on the first day of the Coverage Month; or
- 2) the first day of the next Coverage Month following the date You become eligible for the change in coverage, if the date is after the first day of the Coverage Month.

A change in coverage increasing the amount of coverage above Your GIB offer is subject to:

- 1) satisfactory Evidence of Insurability, at no expense to AUL; and
- 2) AUL's written approval.

If You are not Actively at Work on the effective date of the approved increase, any increase in the amount of coverage takes effect on:

- 1) the first day of the Coverage Month, if You return to Active Work on the first day of the Coverage Month; or
- 2) the first day of the next Coverage Month following Your return to Active Work, if the date is after the first day of the Coverage Month.

SECTION 7 - CONTINUATION OF INSURANCE

CONTINUATION OF INSURANCE

While the policy is in force and if You have ceased Active Work due to:

- 1) Sickness or injury, Personal Insurance and Dependent Insurance existing under the policy may be continued for 9 months following cessation of Active Work; or
- 2) Temporary Lay-off, Personal Insurance and Dependent Insurance existing under the policy may be continued until the 90th day following cessation of Active Work;
- 3) an Employer-approved leave of absence, Personal Insurance and Dependent Insurance existing under the policy may be continued until the 90th day following cessation of Active Work,
- 4) an Employer-approved sabbatical, Personal Insurance may be continued until 12 months following cessation of Active Work; or
- 5) an Employer-approved leave of absence allowed under the Family and Medical Leave Act (FMLA) or state law. Personal Insurance and Dependent Insurance existing under the policy may then be continued until the end of the period allowed under FMLA or state law, whichever is longer.

In all the above Continuation of Insurance situations, benefits under this section will terminate on the earliest of the following:

- 1) the date You return to Active Work;
- 2) the date the required premium payments are not received by AUL;
- 3) the date You die;
- 4) the date You begin full or part-time employment;
- 5) the date the policy, or the Participating Unit's coverage under the policy, terminates;
- 6) the date You notify the Participating Unit that You will not be returning to Active Work;
- 7) the date Your class is no longer offered under the policy;
- 8) the date You are no longer a member in an eligible class;
- 9) the date You make written request for termination of coverage but not prior to the date of the request; or
- 10) the date You enter military service for any country, except for temporary duty not scheduled for more than 30 days.

If the Participating Unit has approved more than one type of leave of absence during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under the policy.

If You do not return to Active Work, Personal Insurance and Dependent Insurance existing under the policy terminates at the end of Continuation of Insurance period. At the end of Continuation of Insurance period You may be eligible to apply for:

- 1) Waiver of Premium for Total Disability, see Section 8, if available;
- 2) Portability, see Section 7A; or
- 3) the Conversion Privilege, see Section 10.

SECTION 7A - PORTABILITY

PORTABILITY

If Your coverage ceases due to:

- 1) loss of eligibility under the policy due to not being Actively at Work or a reduction in hours worked;
- 2) termination of employment; or
- 3) termination of the Participating Unit's coverage under the policy and coverage is not replaced under a similar group insurance policy within 31 days following termination of coverage.

You may continue the amount of Personal Insurance and Dependent Insurance existing under the policy, minus any benefits paid under the policy without interruption until the earlier of:

- 1) the date premium payments are not received by AUL for You; or
- 2) the attainment of age 70.

To continue coverage You must submit written application and the required amount of premium to AUL within 31 days of the date coverage terminated under the policy. Failure to pay the required amount of premium to AUL timely will terminate any coverage under the policy at the end of the period for which the premium has been received. AUL reserves the right to charge an administrative fee to cover administrative expenses.

LIMITATIONS

- 1) If Personal Insurance is based on a function of Your Annual Base Salary, no changes in coverage due to salary increases will be allowed under Section 7A.
- 2) Dependent Insurance may be continued when Your Personal Insurance is continued under Section 7A.
- 3) Your AD&D coverage may be continued under Section 7A, subject to the provisions of the policy.
- 4) Dependent AD&D coverage may be continued when Your AD&D coverage is continued under Section 7A.
- 5) No Waiver of Premium benefits are available under Section 7A.
- 6) No benefits under Section 7A are available to any Employee who is not authorized to reside in the United States or whose domicile is outside of the United States.

If benefits under Section 7A terminates You may convert Your Life Amount and any Dependent Insurance to an individual policy in accordance with Section 10, Conversion Privilege.

AUL may terminate the insurance under this provision at the end of any Coverage Month by giving the Participating Unit and each Portable at least 31 days prior written notice.

See Section 26, Termination of a Portable.

SECTION 8 - WAIVER OF PREMIUM

DEFINITIONS

ELIMINATION PERIOD means a 9 month period of consecutive days of Total Disability. The Elimination Period begins on the 1st day of Total Disability and ends on the last day ending the 9 month period. You may not have more than three (3) days of Active Work during the Elimination Period.

WAIVER OF PREMIUM BENEFIT

AUL will waive further premium payments for Your Life Amount if You:

- 1) become Totally Disabled before age 60 and while insured under the policy;
- 2) remain continuously Totally Disabled during the nine (9) month Elimination Period;
- 3) submit and AUL receives proof of Total Disability within the three (3) months prior to the end of the Elimination Period;
- 4) submit and AUL receives acceptable proof of continuous Total Disability at least annually and as requested by AUL; and
- 5) are under the Regular Attendance of a Physician.

AUL also may require that You be examined:

- 1) at AUL's expense;
- 2) by a Physician of AUL's choice.

While You meet the conditions set forth above and is approved by AUL for the benefit You will retain coverage for the Life Amount without the need to make further premium payments until the first of the following occurs:

- 1) proof of Total Disability is not received by AUL;
- 2) You become employed, or are found able to be employed in an occupation for which You are reasonably fitted by training, education or experience;
- 3) You refuse to undergo a medical examination requested by AUL;
- 4) the date You are not under the Regular Attendance of a Physician;
- 5) proof of continuous Total Disability is not submitted within the twelfth month of any benefit period unless it was not possible to do so;
- 6) You attain age 65;
- 7) You are no longer Totally Disabled.

SECTION 8 - WAIVER OF PREMIUM

When You are approved for coverage under this Waiver of Premium for Total Disability, the coverage existing under the policy for You will reduce based on the reduction schedule in the Schedule of Benefits page.

If You are not approved for this benefit, or if the Waiver of Premium benefit coverage ceases and You do not return to Active Work You may, within 31 days from notice of the adverse benefit determination or the cessation of coverage, apply to:

- 1) continue Your coverage, pursuant to Section 7A, Portability; or
- 2) convert Your Life Amount to an individual life insurance policy, pursuant to Section 10, Conversion Privilege.

If benefits under the Waiver of Premium for Total Disability end because You return to Active Work with the Participating Unit, and the policy is still in force You are eligible to apply for the coverages available to Your class.

If You die during the Elimination Period and benefits are payable under the policy Your Beneficiary will be entitled to the Life Amount.

If benefits are payable under the policy after You are approved for Waiver of Premium and You have applied and been issued an individual life insurance policy under Section 10, Conversion Privilege, any amount payable under the policy will be reduced by the amount payable under the individual life insurance policy. **IN NO EVENT WILL A BENEFIT BE PAYABLE UNDER BOTH THE INDIVIDUAL LIFE INSURANCE POLICY AND THE POLICY GREATER THAN THE LIFE AMOUNT.**

SECTION 9 - INDIVIDUAL TERMINATIONS

Personal Insurance terminates on the earliest of the following dates:

- 1) the date the Participating Unit's coverage under the policy is terminated;
- 2) the date You request termination but not prior to the date of the request;
- 3) the date for which any required premium payment was not received by AUL;
- 4) the date You cease to be eligible, see Section 3, Eligibility;
- 5) the date You enter active military service for any country except for temporary duty of 30 days or less;
- 6) the date You cease Active Work, except for an event listed in the policy in Continuation of Insurance, Section 7;
- 7) the date of an adverse benefit determination under the Waiver of Premium provisions; or
- 8) the date You become a Retiree, unless the Schedule of Benefits includes a specific classification for Retirees.

SECTION 10 - CONVERSION PRIVILEGE

If Your coverage or a portion of it, terminates because You are no longer eligible for coverage under the policy You may apply for an individual life insurance conversion policy without evidence of insurability. The coverage amount of the individual life insurance conversion policy shall not exceed the amount of life insurance that ceases because of loss of eligibility for coverage under the policy minus the amount of any group life coverage for which You become eligible within 31 days of termination.

If Your coverage ceases due to termination of the policy You may apply for and receive an individual life insurance conversion policy if Your group life insurance has been in force with AUL for five (5) continuous years before the termination date. The coverage amount of the individual life insurance conversion policy may not exceed the LESSER of:

- 1) the amount of life insurance that ceases because of termination minus the amount of any group life coverage for which You become eligible within 31 days of termination; or
- 2) \$2,000.

The conversion privilege is subject to the following:

- 1) Written application must be made and the first premium must be paid within 31 days after the date of termination of insurance.
- 2) An individual life insurance policy other than term life insurance, offered by AUL at the time of conversion, may be selected.
- 3) The premium on the individual life insurance policy must be at AUL's then customary rate applicable to the form and amount of the individual life insurance policy, to the class of risk to which You or Your dependent then belong, and to the individual age attained by You or Your dependent on the effective date of the individual life insurance policy.
- 4) The individual life insurance conversion policy takes effect on the last day of the application period and is in lieu of all benefits under the policy.

If notice of the existence of the conversion right is not given at least 15 days before the expiration of the period during which the conversion application and payment of the first premium must be made under the terms of the policy, You have an additional period within which to exercise the conversion right. The additional conversion application period created to exercise a right of conversion expires 15 days after You are given notice of the conversion right. However, irrespective of the date on which notice is given or of the absence of any notice, the additional conversion application period may not extend beyond 60 days after the expiration date of the period within which conversion application period and payment of the first premium were to be made under the terms of the policy. For purposes of this section, notice of the right of conversion may be given to You in writing, presented to You; mailed by the Participating Unit to Your last known address; or mailed by the insurer to Your last known address as furnished by the Participating Unit.

If death occurs during the conversion application period, AUL will pay the Life Amount available for conversion whether or not the application or the first premium payment has been made. After the 31-day period, no conversion application will be accepted unless it is proven that it was not possible for You to apply in a timely fashion. The individual life insurance conversion policy will not include Accidental Death benefits or any other benefits currently in force under the policy.

Premium must be paid to and received by AUL for coverage during the conversion application period.

IF DEATH OCCURS DURING THE CONVERSION APPLICATION PERIOD, IN NO EVENT WILL BENEFITS BE PAYABLE UNDER BOTH THE INDIVIDUAL CONVERSION POLICY AND THE POLICY.

SECTION 11 - INDIVIDUAL REINSTATEMENTS

If Personal Insurance, and Dependent Insurance if any, terminates due to termination of Your employment You can apply to reinstate that coverage following return to Active Work. The following conditions apply:

- 1) When You return to Active Work within 30 days of termination of coverage, coverage becomes effective on the first day of the next Coverage Month following Your return to Active Work. Evidence of Insurability will not be required for any amount of coverage less than the Guaranteed Issue Amount.
- 2) When return to Active Work occurs after the period shown in paragraph 1 above You will be considered a New Employee and must satisfy all New Employee requirements. See Section 3, Eligibility, Enrollment, and Individual Effective Date. Evidence of Insurability will not be required for any amount of coverage less than the Guaranteed Issue Amount.
- 3) When the Life Amount has been converted under the Conversion Privilege, Section 10, the Life Amount available for reinstatement under the policy will be reduced by the amount of coverage under the individual life insurance policy. In no event will the amount of coverage reinstated under this Section and the amount of coverage under the individual life insurance policy be greater than the Life Amount existing on Your termination of employment.
- 4) Prior to applying for reinstatement, AUL must have received the required amount of premium timely.
- 5) The maximum amount of coverage reinstated will not exceed the maximum amount of coverage which would have been available had Your coverage not terminated.

If reinstatement is requested for any reason other than returning to Active Work, medical underwriting and satisfactory Evidence of Insurability, at no expense to AUL, will be required prior to AUL's approval of coverage. The effective date of reinstatement will be the date determined by AUL in writing.

Dependent Insurance cannot be reinstated without reinstatement of Personal Insurance.

IN NO EVENT CAN AN EMPLOYEE HAVE COVERAGES FROM ALL EXISTING AUL GROUP VOLUNTARY TERM LIFE INSURANCE CONTRACTS EXCEEDING THE MAXIMUM AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS.

SECTION 13 - ACCELERATED LIFE BENEFIT

The following definitions apply only to this section:

DEFINITION

TERMINAL CONDITION means an injury or Sickness that, despite appropriate medical care, is conclusively established to AUL will result in Your death within 12 months from the date of claim, AUL may require that You be examined at AUL's expense by AUL's choice of Physician.

ACCELERATED LIFE BENEFIT

If You are diagnosed with a Terminal Condition and are eligible for benefits under this Section, You may apply for payment of the Accelerated Life Benefit. The amount of Accelerated Life Benefit available is shown in the Schedule of Benefits, unless any portion of Your Life Amount has already been paid. The amount of Accelerated Life Benefit available will then be based on the amount remaining after payment of any portion of the Life Amount. Benefits will be paid in one lump sum to You.

CONDITIONS

To be eligible to apply for the Accelerated Life Benefit:

- 1) You must have Personal Insurance;
- 2) You must be diagnosed by a Physician with a Terminal Condition while eligible for benefits under this Section;
- 3) If You are subject to laws of a community property state, you must obtain Your spouse's written consent for payment to You of the Accelerated Life Benefit; and
- 4) You can receive an Accelerated Life Benefit only once.

PROOF REQUIRED FOR THE ACCELERATED BENEFIT

Proof is a completed claim form and other information AUL requires in order to determine whether benefits are owed under this Section. AUL may require that You be examined by a Physician selected by AUL and at AUL's expense.

LIMITATIONS

An Accelerated Life Benefit will not be paid if:

- 1) You have named an irrevocable Beneficiary or made an assignment of Your Life Amount;
- 2) all or a portion of Your Life Amount is to be paid to another person or entity pursuant to a valid court order;
- 3) Your coverage terminates;
- 4) the Participating Unit's coverage under the policy terminates, unless Continuation of Insurance is selected;
- 5) the Portable terminates; or
- 6) the policy terminates.

SECTION 13 - ACCELERATED LIFE BENEFIT
(Continued)

EFFECT OF PAYMENT OF ACCELERATED LIFE BENEFIT

After payment of an Accelerated Life Benefit, Your Life Amount payable at death to Your Beneficiary equals:

- 1) Your Life Amount as if an Accelerated Life Benefit payment had not been made, minus
- 2) the amount of the Accelerated Life Benefit paid, minus
- 3) the interest charge.

The interest charge equals the Accelerated Life Benefit amount, times the number of days from the date of payment to Your date of death divided by 365, times the interest rate. The interest rate will be based on the current 90-day Treasury bill rate existing on the date of payment of the Accelerated Life Benefit.

The required amount of premiums must continue to be received by AUL on the original Life Amount, unless premiums have ceased due to coverage under the Waiver of Premium benefit of the policy.

The AD&D Principal Sum, if any, will not be reduced by payment of the Accelerated Life Benefit.

The following information is used for illustrative purposes only:

Example: Life insurance in force = \$100,000*
Date of receipt of proof of terminal condition = 10/31/05
Date of payment of Accelerated Life Benefit = 11/1/05
Date of death = 2/15/06
Interest rate** = 3.5%

1. Amount of Accelerated Life Benefit = $.50 \times \$100,000 = \$50,000$
2. Interest Charge = $\$50,000 \times (106 \text{ days} / 365 \text{ days}) \times .035 = \508.22
3. Death Benefit Payable = $\$100,000 - \$50,000 - \$508.22 = \$49,491.78$

*Your Life Insurance amount is shown in the Schedule of Benefits in Your insurance certificate.

**The interest rate is equal to the 90-day treasury bill rate on the date of the Accelerated Life Benefit payment.

NOTE: The Accelerated Life Benefit offered under the policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Life Benefit qualifies for such favorable tax treatment, the benefit will be excludable from the Employee's income and not subject to federal taxation. The laws relating to Accelerated Life Benefits are complex. Employees are advised to consult with a qualified tax advisor about circumstances under which they could receive an Accelerated Life Benefit excludable under federal law. Eligibility for Public Assistance: Receipt of an Accelerated Life Benefit may affect the Employee's, their Dependent spouse's, or their family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. Employees are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect the Employee's, their Dependent spouse's, and their family's eligibility for public assistance.

SECTION 14 - SUICIDE LIMITATION

LIMITATION: If You commit suicide, while sane or insane:

- 1) within two (2) years from the effective date of Personal Insurance with AUL, the benefits payable will be limited to the premiums paid under the policy for You; or
- 2) two (2) or more years after the effective date of Personal Insurance with AUL, but within two (2) years of the effective date of an increase in the amount of coverage the benefits payable will be limited to the coverage in effect under the policy prior to the effective date of the increase, if any, plus the premiums paid for the increased coverage.

If the Participating Unit's coverage under the policy replaced a prior carrier's group life insurance coverage and You were insured with the prior carrier's group life insurance policy, the Suicide Limitation period will begin on the effective date of Your coverage with the prior carrier.

SECTION 15 - PAYMENT OF DEATH BENEFITS

If You die while insured under the policy, AUL will pay the benefits owed under the policy to the Beneficiary:

- 1) upon timely receipt of acceptable proof of death; and
- 2) subject to all other provisions of the policy and to Your dated and signed designation.

The following Sections describe the manner in which death benefits are paid.

SECTION 16 - NAMING OF BENEFICIARY

BENEFICIARY means the individual, individuals or entity named by You to receive Your Life Amount.

Unless the policy provides otherwise, AUL will pay benefits according to Your Beneficiary designation.

When You apply for coverage on an AUL-approved form, You should:

- 1) designate the name of one or more Beneficiaries;
- 2) classify the Beneficiaries by order of preference, either primary or contingent; and
- 3) indicate distribution of the proceeds among members of the class of Beneficiaries.

If more than one primary Beneficiary is listed and no distributive share is indicated, then all primary Beneficiaries will share equally. If no primary Beneficiaries outlive You and there is no distributive share indicated among the contingent Beneficiaries, then all contingent Beneficiaries will share equally.

If the policy replaces insurance coverage of another carrier, AUL may, upon written request of the Participating Unit recognize Beneficiary designations in effect under the prior coverage as effective until a new designation is made with AUL, provided that prior designations are in a form acceptable to AUL and the Participating Unit receives AUL's written approval of the form.

CHANGING A BENEFICIARY

You may change a Beneficiary at any time by written request. The request must be completed, signed, dated and filed through the Participating Unit.

AUL may recognize a beneficiary change as of the date the form was signed by You even if You are not alive when AUL receives it. However, AUL is not liable if benefits are paid according to the previous designation before AUL receives the change. If You apply for an individual life insurance conversion policy under Section 10, Conversion Privilege and name a new Beneficiary, AUL will use any beneficiary designated in that application when determining which beneficiary to pay.

AUL reserves the right to require that any Beneficiary designation be acceptable to it and be made pursuant to applicable laws.

SECTION 17 - THE DEATH CLAIM

If You die while insured under the policy, proof of death should be furnished as soon as possible. The claim must be submitted within 12 months of the date of death. The claim may still be considered if it can be shown that timely submission of the claim was not possible due to events beyond the control of the beneficiary, but will not be considered after the applicable statute of limitations has passed.

Proof of death must include:

- 1) a certified death certificate; and
- 2) a completed claim form.

AUL, at its option, may also require:

- 1) return of Your insurance certificate;
- 2) submission of pertinent medical records, including an autopsy report;
- 3) police reports; or
- 4) any other documents AUL may deem reasonably necessary to determine what benefits and to whom benefits are owed.

If the cause of death cannot be clearly established by other means, AUL reserves the right to have a medical examination performed. The examination will be performed:

- 1) at AUL's expense; and
- 2) by a Physician of AUL's choice.

If the policy is no longer in force, proof furnished more than two (2) years from the date of loss must also include:

- 1) proof of employment at death; and
- 2) proof of coverage under the policy at death.

SECTION 18 - DETERMINATION OF DEATH BENEFIT PAYEE

Once acceptable proof of death is received, AUL will determine the Beneficiaries or payees in the following order:

- 1) If more than one primary Beneficiary is listed and no distributive share is indicated, then all primary Beneficiaries will share equally.
- 2) If no primary Beneficiaries outlive You and there is no distributive share indicated among contingent Beneficiaries, then all contingent Beneficiaries will share equally.
- 3) If no named Beneficiaries outlive You or none were named, then at AUL's option, a surviving relative. Relatives will be considered in descending order of preference as follows:
 - a) spouse;
 - b) natural and legally adopted child(ren);
 - c) parent(s); or
 - d) brother(s) and sister(s).
- 4) If Your estate is not substantial and there are no statutory requirements to the contrary, at AUL's option, benefits may be paid to the closest surviving heir(s) under applicable small estate laws.
- 5) If no named Beneficiaries outlive You or none were named, then at AUL's option, Your estate.

AUL may, at its option, pay the proceeds in an amount up to \$250 to any individual appearing to AUL to be legally entitled to payment by reason of having paid funeral or other burial expenses related to Your death.

In the event You and Your Dependents should die simultaneously or if there is no clear evidence as to which individual died first, it shall be presumed that the Dependents should have predeceased You.

If any Beneficiary dies within 15 days after Your death, the Beneficiary will be treated as having died before You. This provision does not apply to any payment mailed to such Beneficiary during the 15 days following Your death, and any payment made in good faith shall fully discharge AUL.

SECTION 19 - SELECTION OF PAYMENT METHOD

The proceeds will be paid in a lump sum unless another payment method is selected or changed by giving written notice to AUL prior to Your death. If no payment method is in effect at death, the payee may select a payment method. For information concerning payment method options, You or payee should contact AUL.

Benefits will be paid only if AUL decides in its discretion the person is entitled to them and after AUL approves the payment method. Any person who becomes entitled to receive any portion of the proceeds under the policy shall be entitled to receive payment of interest if any payment is not received by such person within 30 days after the event giving rise to the obligation and after all requested information is received by AUL. Interest payable shall be calculated at an annual rate after all requested information is received by AUL. The rate of interest payable shall be the lesser of 3% or that rate, as determined from time to time by AUL, applicable to proceeds of life insurance left on deposit with AUL and subject to withdrawal on demand. For the purposes of this section, payment shall be deemed to have been received by the person when deposited by AUL in United States mail, postage prepaid, and directed to the person's last known address or the Participating Unit's address shown in AUL's records.

Other than lump sum payment, AUL reserves the right to specify the minimum periodic payment when a method is to become effective.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20A - DEPENDENT ELIGIBILITY

ELIGIBILITY

All Dependents must be legally authorized to reside in the United States under applicable state and federal laws.

An individual who is Your Dependent on or before the effective date the policy becomes eligible for Dependent Insurance on the later of the following dates:

- 1) the effective date of the Participating Unit's coverage under the policy;
- 2) the date You become eligible for Personal Insurance; or
- 3) the effective date that Dependent coverage under Section 20, Dependent Insurance is added to the Participating Unit's coverage.

An individual who becomes Your Dependent after the effective date of the policy becomes eligible for Dependent Insurance on the later of the following dates:

- 1) the date You become eligible for Personal Insurance;
- 2) the date the individual becomes Your Dependent; or
- 3) the effective date that Dependent coverage under Section 20, Dependent Insurance is added to the Participating Unit's coverage.

You as a condition of insuring Your Dependent(s) must make written election to AUL on a form approved by AUL and must contribute the required amount of premium to AUL on a timely basis.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20B - DEPENDENT INDIVIDUAL EFFECTIVE DATE

INDIVIDUAL EFFECTIVE DATE OF INSURANCE

Dependent Insurance will not become effective for a Dependent until You have Personal Insurance. To receive any amount of coverage exceeding the Guaranteed Issue Amount, You must make a written election to AUL on a form approved by AUL and Your Dependent must undergo medical underwriting.

The effective date of Dependent Insurance for an eligible Dependent, subject to the further provisions of this Section, will be after the Dependent submits satisfactory Evidence of Insurability to AUL and the date AUL determines the Dependent is approved for coverage. Satisfactory Evidence of Insurability, at no expense to AUL, must be provided prior to receiving any amount of coverage greater than the Guaranteed Issue Amount.

During an Employee's Initial Enrollment Period

If You request Dependent Insurance during the Initial Enrollment Period, the Dependent's Individual Effective Date of Insurance will be:

- 1) for amounts of coverage that do not exceed the Guaranteed Issue Amount shown in the Dependent Insurance Schedule of Benefits, the effective date of Dependent Insurance for each Dependent will be Your Individual Effective Date of Insurance; or
- 2) for amounts of coverage exceeding the Guaranteed Issue Amount, the date identified by AUL.

After an Employee's Initial Enrollment Period and within 31 days of acquiring his dependent

If You request Dependent Insurance after Your Initial Enrollment Period and within 31 days of acquiring his Dependent, the Dependent's Individual Effective Date of Insurance will be:

- 1) for amounts of coverage that do not exceed the Guaranteed Issue Amount shown in the Dependent Insurance Schedule of Benefits, the effective date of Dependent Insurance for each Dependent will be the date the Dependent becomes eligible; or
- 2) for amounts of coverage exceeding the Guaranteed Issue Amount, the date identified by AUL.

After an Employee's Initial Enrollment Period and after 31 days of acquiring his dependent

If You request Dependent Insurance after Your Initial Enrollment Period and after 31 days of the individual becoming a Dependent You must make a written election to AUL on a form approved by AUL and the Dependent must undergo medical underwriting. The effective date of Dependent Insurance for an eligible Dependent, subject to the further provisions of this Section, will be after the Dependent submits satisfactory Evidence of Insurability to AUL and the date AUL determines the Dependent is approved for coverage. Satisfactory Evidence of Insurability, at no expense to AUL, must be provided prior to receiving any amount of coverage.

After an Employee's Individual Effective Date of Insurance and within 31 days of acquiring his dependent

If You request Dependent Insurance after Your Individual Effective Date of Insurance but within 31 days of the individual becoming a Dependent, the Dependent's Individual Effective Date of Insurance will be:

- 1) for amounts of coverage that do not exceed the Guaranteed Issue Amount shown in the Dependent Insurance Schedule of Benefits, the effective date of Dependent Insurance for each Dependent will be the first of the Coverage Month following the application; or
- 2) for amounts exceeding the Guaranteed Issue Amount, the date identified by AUL.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20B - DEPENDENT INDIVIDUAL EFFECTIVE DATE
(Continued)

After an Employee's Individual Effective Date of Insurance and after 31 days of the individual becoming a Dependent

If You request Dependent Insurance after Your Individual Effective Date of Insurance and after 31 days of the individual becoming a Dependent You must make a written election to AUL on a form approved by AUL and the Dependent must undergo medical underwriting.

The effective date of Dependent Insurance for an eligible Dependent, subject to the further provisions of this Section, will be after the Dependent submits satisfactory Evidence of Insurability to AUL and the date AUL determines the Dependent is approved for coverage. Satisfactory Evidence of Insurability, at no expense to AUL, must be provided prior to receiving any amount of coverage.

ADDITIONAL PROVISIONS

Any Dependent who converted his insurance under the policy to an individual life insurance policy and if that individual life insurance policy is still in force, the Dependent is required prior to becoming insured again under the policy, to undergo medical underwriting and submit satisfactory Evidence of Insurability, at no expense to AUL. If the Dependent does not wish to undergo medical underwriting and submit satisfactory Evidence of Insurability, the Life Amount under the policy will be reduced by the amount of coverage under the individual life insurance policy. No coverage shall begin until the date AUL has approved the request for coverage in writing and the required amount of premium is received from the Employer.

If You have at least one Dependent Child insured under the Participating Unit's coverage under the policy, insurance amounts for any newly acquired Dependent Child that do not exceed the Guaranteed Issue Amount shown in the Dependent Insurance Schedule of Benefits becomes effective on the date that Dependent Child is acquired. No Evidence of Insurability will be required.

If You have only Dependent Child(ren) insured under the Participating Unit's coverage under the policy, insurance amounts for a newly acquired Dependent spouse requested within 31 days of acquiring the Dependent spouse will become effective:

- 1) for amounts within the Guaranteed Issue Amount, the date the Dependent spouse is acquired; and
- 2) for amounts in excess of the Guaranteed Issue Amount, the date named by AUL.

Satisfactory Evidence of Insurability will be required on amounts in excess of the Guaranteed Issue Amount.

If You have only Dependent Child(ren) insured under the Participating Unit's coverage under the policy, insurance amounts for a newly acquired Dependent spouse requested after 31 days of acquiring the Dependent spouse will require Evidence of Insurability. The spouse's Individual Effective Date of Insurance will be the date named by AUL.

If a Dependent is confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility on the date Dependent Insurance would otherwise become effective for that Dependent, the Individual Effective Date of Insurance for that Dependent is the date following the Dependent's final discharge from the medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility and the resumption of the usual and customary duties or activities of an individual in good health and of the same age and sex. For the purposes of the policy, a Dependent will not cease to be confined if one confinement is followed by another confinement, within 72 hours, for the same or a related injury or sickness. AUL may request satisfactory evidence of good health.

Also see Section 5, Continuity of Coverage.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20C - DEPENDENT CHANGES IN INSURANCE COVERAGE
(Continued)

OTHER INCREASE REQUESTS

During Scheduled Enrollment Periods, You may request to increase coverage up to the next higher amount of Dependent Insurance coverage. You must make a written election to AUL on a form approved by AUL and all Dependents must undergo medical underwriting. The effective date of Dependent Insurance for an eligible Dependent, subject to the further provisions of this Section, will be after all Dependents submit satisfactory Evidence of Insurability to AUL and the date AUL determines all Dependents are approved for coverage. Satisfactory Evidence of Insurability, at no expense to AUL, must be provided prior to receiving any amount of coverage.

EFFECTIVE DATE OF CHANGE

The amount of coverage for which a Dependent is eligible is shown in the Schedule of Benefits.

A change in coverage increasing the amount of coverage is subject to:

- 1) satisfactory Evidence of Insurability, at no expense to AUL; and
- 2) AUL's written approval.

If a Dependent is confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility on the approved change date, any increase in the amount of coverage for that Dependent takes effect on:

- 1) the date of the Dependent's final discharge from the medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility and the resumption of the usual and customary duties or activities of an individual in good health and of the same age and sex, if the date is the first day of the Coverage Month; or
- 2) the first day of the next Coverage Month following the Dependent's final discharge from the medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility and the resumption of the usual and customary duties or activities of an individual in good health and of the same age and sex, if the date is after the first day of the Coverage Month.

AUL may request satisfactory evidence of good health.

For the purposes of the policy, a Dependent will not cease to be confined if one confinement is followed by another confinement, within 72 hours, for the same or a related injury or sickness.

A Dependent's insurance terminates on the earliest of the following dates:

- 1) the date the Participating Unit's coverage under the policy or this section is terminated;
- 2) the date You request termination, but not prior to the date of the request;
- 3) the last date for which any required premium payment was not received by AUL;
- 4) the date the Dependent ceases to be eligible;
- 5) the date the Personal Insurance terminates;
- 6) the date the Waiver of Premium benefit request for You is approved;
- 7) the date of an adverse benefit determination under the Waiver of Premium provisions, if applicable; or
- 8) the date You become a Retiree, unless the Schedule of Benefits includes a specific classification for Retirees.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20F - DEPENDENT CONVERSION PRIVILEGE

CONVERSION PRIVILEGE

If a Dependent's coverage, or a portion of it, terminates because the Dependent is no longer eligible for coverage under the policy, the Dependent may apply for an individual life insurance conversion policy without evidence of insurability. The coverage amount of the individual life insurance conversion policy shall not exceed the amount of life insurance that ceases because of loss of eligibility for coverage under the policy minus the amount of any group life coverage for which the Dependent becomes eligible within 31 days of termination.

If the Dependent's coverage ceases due to termination of the policy, the Dependent may apply for and receive an individual life insurance conversion policy if the Dependent's group life insurance has been in force with AUL for five (5) continuous years before the termination date. The coverage amount of the individual life insurance conversion policy may not exceed the LESSER of:

- 1) the amount of life insurance that ceases because of termination minus the amount of any group life coverage for which the Dependent becomes eligible within 31 days of termination; or
- 2) \$2,000.

The conversion privilege is subject to the following:

- 1) Written application must be made and the first premium must be paid within 31 days after the date of termination of insurance.
- 2) An individual life insurance policy, other than term life insurance, offered by AUL at the time of conversion, may be selected.
- 3) The premium on the individual policy must be at AUL's then customary rate applicable to the form and amount of the individual life insurance policy, to the class of risk to which You or Your dependent then belongs, and to the individual age attained by You or Your dependent on the effective date of the individual life insurance policy.
- 4) The individual life insurance conversion policy takes effect on the last day of the application period and is in lieu of all benefits under the policy.

If notice of the existence of the conversion right is not given at least 15 days before the expiration of the period during which the conversion application and payment of the first premium must be made under the terms of the policy, the Dependent has an additional period within which to exercise the conversion right. The additional conversion application period created to exercise a right of conversion expires 15 days after the Dependent is given notice of the conversion right. However, irrespective of the date on which notice is given or of the absence of any notice, the additional conversion application period may not extend beyond 60 days after the expiration date of the period within which conversion application and payment of the first premium were to be made under the terms of the policy. For purposes of this section, notice of the right of conversion may be given to the Dependent in writing presented to the Employee; mailed by the Participating Unit to the last known address of the Dependent; or mailed by AUL to the last known address of the Dependent as furnished by the Participating Unit.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20F - DEPENDENT CONVERSION PRIVILEGE
(Continued)

If death occurs during the conversion application period, AUL will pay the Dependent Life Amount available for conversion whether or not the application or the first premium payment has been made. After the 31-day period, no conversion application will be accepted unless it is proven that it was not possible for the Dependent to apply in a timely fashion. The individual life insurance conversion policy will not include Accidental Death benefits or any other benefits currently in force under the policy.

Premium must be paid to and received by AUL for coverage during the conversion application period.

IF DEATH OCCURS DURING THE CONVERSION APPLICATION PERIOD, IN NO EVENT WILL BENEFITS BE PAYABLE UNDER BOTH THE INDIVIDUAL CONVERSION POLICY AND THE POLICY.

See Individual Reinstatements, Section 11.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20H - DEPENDENT SPOUSE ACCELERATED LIFE

The following definition applies only to this section:

DEFINITION

TERMINAL CONDITION means an injury or Sickness that, despite appropriate medical care, is conclusively established to AUL will result in the Dependent spouse's death and/or domestic partner's death (thereafter, within this Dependent Spouse Accelerated Life Benefit Section, references to Spouse includes domestic partner) within 12 months from the date of claim. AUL may require that the Dependent spouse be examined at AUL's expense by AUL's choice of Physician.

DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT

If a Dependent spouse is diagnosed with a Terminal Condition and is eligible for benefits under this Section You may apply for payment of the Dependent Spouse Accelerated Life Benefit. The amount of Dependent Spouse Accelerated Life Benefit available is shown in the Schedule of Benefits, unless any portion of the Dependent Spouse's Life Amount has already been paid. The amount of Dependent Spouse Accelerated Life Benefit available will then be based on the amount remaining after payment of any portion of the Life Amount. Benefits will be paid in one lump sum to You.

CONDITIONS

To be eligible to apply for the Dependent Spouse Accelerated Life Benefit:

- 1) You must have Dependent Insurance that includes this Dependent Spouse Accelerated Life Benefit provision;
- 2) the Dependent spouse must be diagnosed by a Physician with a Terminal Condition while eligible for benefits under this Section;
- 3) A Dependent who is subject to laws of a community property state, obtains the spouse's written consent for payment to You of the Dependent Spouse Accelerated Life Benefit; and
- 4) You can receive a Dependent Spouse Accelerated Life Benefit only once.

PROOF REQUIRED FOR THE DEPENDENT SPOUSE ACCELERATED BENEFIT

Proof is a completed claim form and any other information AUL requires in order to determine whether benefits are owed under this Section. AUL may require that the Dependent spouse be examined by a Physician selected by AUL and at AUL's expense.

LIMITATIONS

A Dependent Spouse Accelerated Life Benefit will not be paid if:

- 1) the Dependent spouse's coverage under the policy terminates;
- 2) the Participating Unit's coverage under the policy terminates, unless Continuation of Insurance is selected;
- 3) the Portable terminates; or
- 4) the policy or provision terminates.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20H - DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT
(Continued)

EFFECT OF PAYMENT OF DEPENDENT SPOUSE ACCELERATED LIFE BENEFIT

After payment of a Dependent Spouse Accelerated Life Benefit, the Dependent spouse's Life Insurance amount payable at death to You equals:

- 1) the amount of the Dependent spouse's Life Insurance as if a Dependent Spouse Accelerated Life Benefit payment had not been made, minus
- 2) the Dependent Spouse Accelerated Life Benefit payment, minus
- 3) the interest charge.

The interest charge equals the Dependent Spouse Accelerated Life Benefit amount times the number of days from the date of payment to the Dependent spouse's date of death, divided by 365, times the interest rate. The interest rate will be based on the current 90-day treasury bill rate existing on the date of payment of the Dependent Spouse Accelerated Life Benefit.

Dependent Insurance premiums continue to be due and payable on the original Dependent Insurance amount, unless premiums have ceased due to the Dependent Spouse's coverage under the Dependent Life Insurance Waiver of Premium provision, if any, of the policy.

The Dependent Spouse's Accidental Death and Dismemberment Insurance, if any, will not reduce due to payment of the Dependent Spouse Accelerated Life Benefit as long as the Dependent Spouse's Accidental Death and Dismemberment Insurance remains in force.

The following information is used for illustrative purposes only:

Example: Dependent spouse life insurance coverage in force = \$50,000*
 Date of receipt of proof of terminal condition = 10/31/05
 Date of payment of Accelerated Life Benefit = 11/1/05
 Date of death = 2/15/06
 Interest rate** = 3.5%

- 1) Amount of Accelerated Life Benefit = $.50 \times \$50,000 = \$25,000$
- 2) Interest Charge = $\$25,000 \times (106 \text{ days} / 365 \text{ days}) \times .035 = \254.11
- 3) Death Benefit Payable = $\$50,000 - \$25,000 - \$254.11 = \$24,745.89$

*The Dependent spouse's Life Insurance amount is shown in the Schedule of Benefits in the Employee's insurance certificate.

**The interest rate is equal to the 90-day treasury bill rate on the date of the Accelerated Life Benefit payment.

NOTE: The Accelerated Life Benefit offered under the policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Life Benefit qualifies for such favorable tax treatment, the benefit will be excludable from the Employee's income and not subject to federal taxation. The laws relating to Accelerated Life Benefits are complex. Employees are advised to consult with a qualified tax advisor about circumstances under which they could receive an Accelerated Life Benefit excludable under federal law. Eligibility for Public Assistance: Receipt of an Accelerated Life Benefit may affect the Employee's, their Dependent spouse's, or their family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. Employees are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect the Employee's, their Dependent spouse's, and their family's eligibility for public assistance.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20I - DEPENDENT SUICIDE LIMITATION

SUICIDE LIMITATION:

LIMITATION: If the Dependent commits suicide, while sane or insane:

- 1) within two (2) years from the Dependent's effective date of Dependent Life Insurance with AUL, the benefits payable will be limited to the premiums paid for the Dependent Insurance; or
- 2) two (2) or more years after the effective date of the Dependent's Life Insurance with AUL, but within two (2) years of the effective date of an increase in the amount of the Dependent's Life coverage, the benefits payable will be limited to the Dependent's Life coverage obtained prior to the effective date of the increase in the Dependent's Life Insurance, if any, plus the premiums paid for the increased Dependent Insurance.

If the Participating Unit's coverage under the policy replaced a prior carrier's group life insurance coverage and the Dependent was insured with the prior carrier's group life insurance policy, the Suicide Limitation period will begin on the effective date of the Dependent's coverage with the prior carrier.

SECTION 20 - DEPENDENT INSURANCE
SECTION 20J - DEPENDENT PAYMENT OF DEATH BENEFITS

PAYMENT OF DEATH BENEFITS

Upon the death of an insured Dependent, benefits will be paid:

- 1) to You;
- 2) to Your Beneficiary, if You are not living; or
- 3) as provided in Section 18, Determination of Death Benefit Payee.

Benefits will be paid in a lump sum.

SECTION 20K - DEPENDENT TERMINATION

TERMINATION OF THIS SECTION

The Participating Unit may terminate this section at the end of any Coverage Month by giving AUL 31 days prior written notice.

AUL may terminate the insurance provided under this section at the end of any Coverage Month by giving at least 31 days prior notice to the Participating Unit.

AUL WILL STILL BE LIABLE FOR PAYMENT OF VALID CLAIMS INCURRED BEFORE THE TERMINATION DATE.

SECTION 21 - GENERAL POLICY PROVISIONS

ENTIRE CONTRACT: The policy, the enrollment forms of the individuals, the application of the Participating Unit, the application/Subscription Agreement of the Participating Unit, and any amendments made from time to time constitute the entire contract.

AMENDMENT and CHANGES: A Participating Unit's coverage under the policy may be amended by mutual agreement between the Participating Unit and AUL but without prejudice to any valid claim incurred prior to the effective date of the amendment. The policy may be changed or corrected by AUL at any time. However, no change in the Participating Unit's coverage under the policy will be valid unless written notice is provided by AUL containing the signature of its Chief Executive Officer or Secretary. No agent may or has the authority to waive, alter or change any terms and conditions of the policy or coverage.

SUBSCRIPTION AGREEMENT: An approved copy of the Subscription Agreement will be given to the Participating Unit when coverage is approved and offered by AUL. All statements made by an Employee or Dependents are deemed representations and not warranties. No statement made by an Employee or a Dependent may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Employee or Dependent or, in the event of death or incapacity of the Employee or Dependent, to the Employee's or Dependent's Beneficiary or personal representative.

INCONTESTABILITY: The validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two years after its date of issue, and other than a misrepresentation of a material fact, no statement made by a Participating Unit or an Employee or a Dependent relating to his insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless: (1) the insurance has not been in force for a period of two years or longer; or (2) the statement is contained in a written instrument signed by the Employee or the Dependent. However, AUL is not precluded from asserting at any time any defenses based upon provisions in the policy relating to eligibility for coverage. All statements made by the Employee or Dependents insured are to be deemed representations and not warranties, and that other than a misrepresentation of a material fact no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Employee or Dependents or, in the event of death or incapacity of the Employee or Dependent, to the Employee's or Dependent's beneficiary or personal representative.

INSURANCE FRAUD: AUL wants to ensure that its customers do not incur additional insurance costs as a result of the act of insurance fraud. AUL promises to focus on all means necessary to support fraud detection, investigation and prosecution.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison

RELATIONSHIP: AUL and the Participating Unit are, and will remain, independent contractors. Nothing in the policy shall be construed as making the parties joint ventures or as creating a relationship of employer and employee, master and servant, or principal and agent. Neither party has any power, right or authority to bind the other or to assume or create any obligation or responsibility on behalf of the other. AUL and the Participating Unit each retain exclusive control of their time and methods to perform their respective duties. AUL and the Participating Unit will employ, pay and supervise their own employees and pay their own expenses during the term of the policy.

SECTION 21 - GENERAL POLICY PROVISIONS
(Continued)

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if AUL decides in its discretion that the applicant is entitled to them. Except for the functions the policy explicitly reserves to a Participating Unit, AUL reserves the right to:

- 1) manage the policy and administer claims under it; and
- 2) interpret the provisions and resolve questions arising under it.

AUL's authority includes, but is not limited to, the right to:

- 1) establish and enforce procedures for administering the policy and claims under it;
- 2) determine applicant's eligibility for insurance and entitlement to benefits;
- 3) determine what information AUL reasonably requires to make such decisions; and
- 4) resolve all matters when a claim review is requested.

Any decision that AUL makes, in the exercise of its authority, will be conclusive; subject to the Employee's or beneficiary's right to request reviews allowed under applicable laws.

GRACE PERIOD: Premiums are due monthly and must be received by AUL within the required time frame for coverage to remain in force. The Employee is entitled to a grace period of 31 calendar days for the payment of any premium due except the first. During the grace period, the insurance coverage shall continue in force, unless AUL has received written notice of termination in advance of date of termination and in accordance with the terms of the policy. A Participating Unit is liable to AUL for the payment of a pro rata premium for the time the policy was in force during the grace period. If the required amount of premium is not received by the end of the grace period, the insurance will terminate as of the last day of coverage for which premium was paid.

LEGAL ACTION: No legal action may be brought to obtain benefits under the policy:

- 1) for at least 60 days after proof of loss has been furnished and before arbitration is held pursuant to the arbitration provisions in the policy; or
- 2) after three (3) years from the time written proof of loss is required to have been furnished to AUL.

CONFORMITY WITH STATE LAWS: Any provision of the policy in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of those laws.

DATA AND RECORDS: The Participating Unit must furnish information which AUL reasonably requires. The Participating Unit's documents which may have a bearing on the insurance shall be open for inspection by AUL at all reasonable times.

GENDER PRONOUNS: Whenever the male pronoun is used, it shall also mean the female.

SECTION 21 - GENERAL POLICY PROVISIONS
(Continued)

ERISA APPEAL GUIDELINES WHEN POLICY IS GOVERNED BY ERISA: If a claimant wishes to appeal AUL's decision, claimants are allowed 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants are allowed the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. 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. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of 29 C.F.R. Section 2560.503-1. AUL's review will take 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 benefit determination. A claimant has a right to obtain the information about any voluntary appeal procedures offered by the plan described in paragraph (c)(3)(iv) of 29 C.F.R. Section 2560.503-1 and has a right to bring an action under section 502(a) of ERISA. A final determination will be provided pursuant to 29 C.F.R. Section 2560.503-1.

CERTIFICATES: AUL will issue certificates to the Participating Unit for delivery to the insured Employee. The certificate will summarize the Participating Unit's coverage under the policy and will state:

- 1) the benefits provided; and
- 2) to whom the benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of the policy, the provisions of the policy will govern.

ASSIGNMENT: A Participating Unit may not assign any benefits or rights under the policy without first receiving AUL's written approval.

You may make an absolute assignment of all benefits and rights of his coverage. Any coverage is assignable to the extent permitted by the law except that no collateral assignment is permitted. No assignment is binding unless filed with AUL in a form acceptable to it. AUL assumes no responsibility for the validity or effect of any assignment.

CLAIMS OF CREDITORS: The benefits paid under the policy will be exempt from the claims of creditors to the maximum extent permitted by law.

CLERICAL ERROR: Clerical error on the part of the Participating Unit or AUL will not invalidate insurance otherwise in force or continue insurance otherwise terminated. Upon discovery of an error, an equitable adjustment will be made in the premiums and/or benefits, if appropriate.

MISSTATEMENT OF AGE: If the age of an Employee or Dependent has been misstated, the benefits will be payable based on the true facts. Premium adjustment will be made so that AUL will receive the actual premium required based on the true facts. Any adjustment of benefits due to the correction of age will also be made.

SECTION 21 - GENERAL POLICY PROVISIONS
(Continued)

ARBITRATION: Any controversy or claim arising out of or relating to the policy, the sale or solicitation of the policy, or its breach thereof whether in tort, contract, breach of duty (including but not limited to) any alleged fiduciary, good faith and fair dealing duties, shall be decided by arbitration in accordance with the Federal Arbitration Act, the procedures of the commercial arbitration rules of the American Arbitration Association, and this agreement. The Court of Arbitrators, which is to be held in the county seat where the Participating Unit resides, shall consist of three (3) arbitrators familiar with group insurance and employee welfare benefit plans. The selection of the arbitrators shall be conducted within 30 days after proper service of a demand for arbitration. One of the arbitrators shall be appointed by AUL, one by the insured, and the third shall be selected by the first two appointees prior to the beginning of arbitration. Should the two arbitrators be unable to agree upon the choice of a third, the appointment shall be left to the President or any Vice President of the American Arbitration Association. The arbitrators shall decide by a majority of votes, the award shall be in writing, the decision shall be signed by a majority of the arbitrators, and they shall include a statement regarding the reasons for the disposition of any claim. Judgment on the award rendered by the arbitrators may be entered by any court having jurisdiction thereof. The parties are not precluded from challenging the decision under the Federal Arbitration Act or applicable law. Unless not allowed under applicable law, each party shall bear the expense of its own attorney and arbitrator, and shall share equally with the other party the expenses of the third arbitrator and of the arbitration.

The parties agree that AUL is engaged in interstate commerce, and the transaction is governed by the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

Consistent with the expedited nature of arbitration, each party will, upon the written request of the other party, promptly provide the other with copies of documents relevant to the issues raised by any claim or counterclaim on which the producing party may rely in support of or in opposition to any claim or defense. Any dispute regarding discovery, or the relevance or scope thereof, shall be determined by the arbitrator(s), which determination shall be conclusive. All discovery shall be completed within 60 days following the appointment of the arbitrator(s) or longer following mutual agreement by the parties.

SECTION 22 - PREMIUM PAYMENT

Each premium is remitted in United States dollars by the Participating Unit or by the Portable to AUL on or before its due date. Upon the request of the Participating Unit and the written consent of AUL, the interval of payment may be changed. Payment of any premium does not maintain the insurance in force beyond the end of the period for which the premium has been paid or after the policy has terminated except as provided under the Grace Period or Portable provision.

AUL reserves the right to change premium rates on:

- 1) any date after the Participating Unit's coverage has been in effect for 2 years by giving written notice to the Participating Unit at least 31 days before the date the change is to become effective;
- 2) any date the benefit or eligibility provisions of the policy are changed;
- 3) any date the number of Employee's insured through the changes by 25% or more;
- 4) any date an Insured Unit is added to the policy; or
- 5) any date on which AUL learns any information provided by the Participating Unit prior to and after the date of the application for insurance was not true or accurate and would have changed any coverage, changed the premium rates, and/or would have required further evaluation by AUL prior to AUL's approval of coverage.

Increases in premium due to:

- 1) age bracket changes, if any; or
- 2) salary changes (if benefits are based on a function of salary)

will be effective on the Participating Unit's Anniversary Date following the date of change.

SECTION 23 - INSURED UNITS

PROVISIONS APPLICABLE TO ELIGIBLE UNITS

The Participating Unit is liable for all premiums due for an Insured Unit during any period of time it is an Insured Unit under the policy.

EFFECTIVE DATE

Insurance for an Eligible Unit becomes effective on:

- 1) the effective date of the policy is when the Eligible Unit is approved for coverage by AUL and shown in the Subscription Agreement; or
- 2) the effective date of an amendment to the policy showing AUL has added and approved the Eligible Unit for coverage.

TERMINATION

Insurance for an Insured Unit ceases on the earliest of the following dates:

- 1) the date the Insured Unit no longer meets the definition of an Eligible Unit;
- 2) the date the Insured Unit ceases active business operations or is placed in bankruptcy or receivership;
- 3) the date the Insured Unit loses its entity by means of dissolution, merger, or otherwise;
- 4) the date the Insured Unit is eliminated as an Insured Unit by an amendment to or change in the policy; or
- 5) the last day of the Coverage Month for which any required premium payment is not made for the Insured Unit's insurance.

Any rights of an Employee whose insurance is terminated due to the termination of an Insured Unit are determined the same as if the Participating Unit's coverage under the policy had terminated on that date.

Any references to Participating Unit or Employer used in the policy shall include Insured Units.

SECTION 24 - TERMINATION OF THE POLICY

AUL may terminate the policy at the end of any Coverage Month by giving at least 31 days prior notice to the Participating Unit or Portable. AUL will still be liable for payment of valid claims incurred and benefits owed under the policy before the termination date.

SECTION 25 - TERMINATION OF A PARTICIPATING UNIT

Insurance for a Participating Unit ceases on the earliest of:

- 1) the date the Participating Unit no longer meets the definition of the Participating Unit or assigns the policy to another entity without AUL's written approval;
- 2) the date the Participating Unit ceases business operations or is placed in bankruptcy or receivership;
- 3) the date the Participating Unit loses its entity by means of dissolution, merger, majority change in ownership, transfer of assets, transfer of employees to another entity, etc or otherwise;
- 4) the date the Participating Unit is removed as a Participating Unit by an amendment to or change in the policy;
- 5) the last date of the Coverage Month for which the required premium payment is made;
- 6) the last day of a Coverage Month, provided that AUL has given at least 31 days prior written notice to the Participating Unit;
- 7) the last day of a Coverage Month, if the Participating Unit has given AUL at least 31 days prior written notice;
- 8) the date, as determined by AUL, that the Participating Unit fails to promptly furnish any information which AUL may reasonably require;
- 9) the date, as determined by AUL, that the Participating Unit, without good and sufficient cause, fails to perform in good faith its duties pertaining to the policy; or
- 10) the date on which AUL learns any information provided by the Participating Unit prior to and after the date of the application for insurance was not true or accurate and the policy would not have been issued had AUL known the true facts.

If an Employee's insurance is terminated due to the termination of a Participating Unit, the Employee's rights under the policy are determined as the date the Participating Unit's coverage terminated.

If the policy terminates, the Participating Unit will remain liable to AUL for unpaid premiums for periods during which the coverage existed.

Following termination of Coverage for a Participating Unit or Employee, reinstatement of the coverage will only occur following evaluation and AUL's written approval.

SECTION 26 - TERMINATION OF A PORTABLE

Insurance for a Portable unit terminates on the earliest of:

- 1) the last date of the Coverage Month for which the required premium payment is made;
- 2) the last day of the Coverage Month in which the Portable requests termination, but not prior to the request;
- 3) the last day of the Coverage Month during which the Portable attains age 70;
- 4) the date the Portable becomes insured for AUL Group Voluntary Term Life Insurance through an Employer; or
- 5) the last day of a Coverage Month, provided that AUL has given at least 31 days prior written notice to the Portable.

Following termination of coverage for Portable, reinstatement of the coverage will only occur following evaluation and AUL's written approval.

Upon termination of the Portable, an insured person may elect coverage under a life insurance conversion policy.

**SUMMARY OF THE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
AND
NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS**

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the association.

Coverage

Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

Persons holding such policies or contracts are not protected by this association if:

1. they are not residents of the State of Pennsylvania, except under very specific circumstances;
2. the insurer was not authorized to do business in Pennsylvania at the time the policy or contract was issued;
3. their policy was issued by a nonprofit hospital or health service corporation (e.g. a Blue Cross or Blue Shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

1. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
2. any policy of reinsurance (unless an assumption certificate was issued);
3. plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
4. interest rate yields that exceed an average rate;
5. dividends;
6. experience rating credits;
7. credits given in connection with the administration of a policy or contract;
8. annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
9. policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
10. sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
11. unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
12. financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
13. any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits on Amount of Coverage

The act also limits the amount the association is obligated to pay out; the association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall \$300,000 limit, the association will pay up to \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender or withdrawal values. For annuities, the association will pay up to \$300,000 in annuity benefits, or \$100,000 in net cash surrender or withdrawal benefits. For health insurance, the association will pay up to \$100,000, including any net cash surrender or withdrawal benefits.



**AMERICAN UNITED LIFE INSURANCE COMPANY®
INDIANAPOLIS, INDIANA 46206-0368**

Certifies that it has issued and delivered a policy to:

Insight Pennsylvania Cyber Charter School
(Hereinafter called the Policyholder)

Policy Number: G 00618131-0000-000
Class: 001

Change Effective Date: Does Not Apply

This certificate replaces any and all certificates previously issued to the insured Person under the policy indicated above.

American United Life Insurance Company® (AUL) certifies that the Person whose enrollment form is on file with the Policyholder or AUL as being eligible for insurance and for whom the required premium has been paid, is insured under the above numbered policy for group insurance benefits as designated in the Schedule of Benefits. Benefits as described in this certificate are subject to change.

This certificate describes the coverage provided in the policy. The policy determines all rights and benefits in this certificate and may be amended, canceled or discontinued at any time by agreement between AUL and the Policyholder without notice to the Person.

The policy may be examined at the main office of AUL during regular office hours.

Thomas M. Zurek
Secretary

J. Scott Davison
Chairman, President and Chief Executive Officer

**CERTIFICATE OF INSURANCE
GROUP WORKSITE DISABILITY INSURANCE - SHORT TERM**

TABLE OF CONTENTS

PROVISIONS	SECTION
Schedule of Benefits	1
Definitions	2
Eligibility, Enrollment and Individual Effective Date of Insurance	3
Changes in Insurance	4
Terminations	5
Individual Reinstatement	5A
Continuation of Personal Insurance under FMLA	5B
Continuation of Personal Insurance During a Leave of Absence and Temporary Layoff	5C
Continuation of Personal Insurance During a Leave of Absence for Active Military Service	5D
Premium Payment	6
General Policy Provisions	7
Claim Procedures	7A
Insuring Provisions	8
Exclusions	9
Portability Privilege	14
Vocational Rehabilitation Program	16A
Workplace Modification Benefit	17

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBLE CLASS	All Eligible Full-Time Employees Electing Option 1
CLASS NUMBER	001
OPTION NUMBER	01
REQUIREMENT FOR FULL-TIME EMPLOYEES	30.00 hours or more per week. See Section 3.
BASIC WEEKLY EARNINGS DESCRIPTION	For Sub-Chapter S-Corporation Shareholders: See Section 2. For Principals of a Partnership: See Section 2. For Sole Proprietors: See Section 2. For all other Employees: BWE Without Plan Contributions and No Commissions or Bonuses. See Section 2.
CHANGES IN INSURANCE	First of the Month. See Section 4.
CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)	This benefit is included for this class. See Section 5B.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF	This benefit is included for this class. See Section 5C.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE	This benefit is included for this class. See Section 5D.
COVERED WEEKLY EARNINGS	The amount of the Person's income in U.S. dollars, received from the Policyholder that is insured by the policy. This amount will be the LESSER of: 1) the Basic Weekly Earnings; or 2) the Maximum Weekly Benefit divided by the benefit percentage shown on the Schedule of Benefits.

SECTION 1 - SCHEDULE OF BENEFITS (continued)

Class 001-Option 01

ELIMINATION PERIOD	
INJURY	14 days. See Section 2.
SICKNESS	14 days. See Section 2.
GUARANTEED ISSUE AMOUNT	\$1,000. See Section 2.
LATE ENROLLEE	The Lesser of: 1) 60% of Pre-Disability Earnings; or 2) \$1,000. See Section 3.
INDIVIDUAL EFFECTIVE DATE	
INITIAL EMPLOYEES	Policyholder's Effective Date if the Employee has satisfied his Waiting Period on or before said date, otherwise the first day of the Coverage Month following the Initial Enrollment Period. See Section 3.
NEW EMPLOYEES	First day of the Coverage Month following the Initial Enrollment Period. See Section 3.
INDIVIDUAL REINSTATEMENT	This provision is included for this class. Application must be made within 30 days from termination date. Effective first day of the Coverage Month. See Section 5A.
INDIVIDUAL TERMINATIONS	Immediate. See Section 5.
INITIAL ENROLLMENT PERIOD	
INITIAL EMPLOYEES	Between 11/15/2018 and 12/31/2018.
NEW EMPLOYEES	31 days following the Employee's Eligibility Date. See Section 3.
MAXIMUM BENEFIT DURATION	13 Weeks. See Section 2.
MAXIMUM WEEKLY BENEFIT	\$1,000. See Section 2.
MINIMUM WEEKLY BENEFIT	\$25. See Section 8.
OCCUPATIONAL INJURY OR SICKNESS	Non-Occupational. See Section 2.
ORGAN DONOR TRANSPLANT BENEFIT	This benefit is included for this class. See Section 8.
OTHER INCOME BENEFITS	Applies to this class. See Section 2.
PARTIAL DISABILITY	This benefit is included for this class. See Section 8.
POLICY MONTH	A period that begins on the first day of the month and ends on the last day of the month. Each succeeding Policy Month runs for a similar period thereafter.
PORTABILITY PRIVILEGE	This benefit is included for this class. See Section 14.

SECTION 1 - SCHEDULE OF BENEFITS (continued)

Class 001-Option 01

PRE-EXISTING CONDITION DURATION	3/12. See Section 9.
RECURRENT DISABILITY	30 days. See Section 8.
RESIDUAL BENEFIT	This benefit is included for this class. See Section 8.
SCHEDULED ENROLLMENT PERIOD	Period of time chosen by the Policyholder and approved by AUL. See Section 3.
SOCIAL SECURITY INTEGRATION	Direct Full Family. See Section 8.
TOTAL DISABILITY DEFINITION	Regular Job. See Section 2.
VOCATIONAL REHABILITATION PROGRAM (VOLUNTARY)	This benefit is included for this class. See Section 16A.
WAITING PERIOD	0 days. See Section 2.
WAIVER OF PREMIUM	This benefit is included for this class. See Section 6.
WEEKLY BENEFIT	60% of Basic Weekly Earnings not to exceed Maximum Weekly Benefit of \$1,000. The Weekly Benefit will be reduced by Other Income Benefits. See Section 8.
WORKPLACE MODIFICATION BENEFIT	This benefit is included for this class. See Section 17.

SECTION 2 - DEFINITIONS

ACTIVE WORK and ACTIVELY AT WORK means the use of time and energy in the services of the Policyholder at the regular place of employment, or an alternative worksite as approved by the Policyholder and AUL, by a Person who is physically and mentally capable of performing each of the Material and Substantial duties of his Regular Job and who is a Full-Time Employee. If the alternative worksite is located outside of the United States or Canada, the Person will be considered to be Actively at Work unless the Person is outside of the United States or Canada for more than 6 months in any 12 month period. Active Work does not include periods of time when an Employee is not Actively at Work following an Injury, accidental bodily injury, Sickness, strike, lock-out, or Temporary Layoff.

This includes time off for vacation, jury duty, paid holidays, and funeral leave, where the Person could have been Actively at Work on that day.

ANY OCCUPATION means a Person's occupation for which he receives remuneration.

SECTION 2 - DEFINITIONS

For sub-chapter S corporation shareholders: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars before taxes, received from the Policyholder. Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability and is further based on:

- 1) the weekly average of the Person's gross income on his last reported Federal IRS W-2 Form shown as wages, tips, and other compensation. Earnings include pre-tax contributions to an employer-sponsored defined contribution plan and a cafeteria plan, if any. If the Person has not worked long enough to receive a Federal IRS W-2 Form from the Policyholder, gross weekly income will be the weekly average of the last amount of gross income reported to AUL in writing by the Policyholder for which premiums were paid and the coverage amount was approved in writing by AUL; and
- 2) shareholder earnings reported as ordinary income (loss) for trade or business activities on the Sub S corporation's Federal IRS Tax Form Schedule K-1 1120S, or similar form acceptable to AUL, averaged for the LESSER of:
 - a) the most recent 3 years; or
 - b) the period that the Person has been a shareholder.

The last reported earnings should be adjusted annually upon completion of the tax form, a copy of which should be submitted to AUL. AUL will use the earnings amount last reported in writing, for which premiums were paid, and the coverage amount was approved by AUL in writing before the Person's Date of Disability.

For principals of a partnership: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars before taxes, received from the Policyholder, not to exceed a maximum workweek of 40 hours including Partnership Earnings. Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings do not include income received from commissions, bonuses, overtime, or expense accounts.

Partnership Earnings will be the weekly average of the amount shown as "net earnings (loss) from self-employment" from Schedule K-1 of the partnership federal income tax return for the LESSER of:

- 1) the 3 most recent years; or
- 2) the total number of months the Person was a partner, if the Person was not a partner for the entire 3 years.

The reported earnings should be adjusted annually upon completion of the tax form, a copy of which should be submitted to AUL. AUL will use the earnings amount last reported and approved in writing by AUL before the Person's Date of Disability.

SECTION 2 - DEFINITIONS

For sole proprietors: BASIC WEEKLY EARNINGS means the Person's annual net profit in U.S. dollars averaged for the LESSER of:

- 1) the 3 most recent years; or
- 2) the period that the Person has been a sole proprietor.

Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings are based upon the number taken from Schedule C of Federal IRS Form 1040 for the weekly average of 3 business years immediately prior to reporting. The reported earnings should be adjusted annually following completion of the appropriate tax form, a copy of which should be submitted to AUL. AUL will use the net profit amount last reported in writing, for which premiums were paid and the coverage amount was approved in writing by AUL before the Person's Date of Disability.

SECTION 2 - DEFINITIONS

For all other Employees: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars, before taxes, received from the Policyholder not to exceed a maximum workweek of 40 hours. Gross weekly income does not include pre-tax contributions to an employer sponsored defined contribution plan and a cafeteria plan, if any. These earnings are based on the amount as last reported to AUL in writing by the Policyholder, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings do not include income received from commissions, bonuses, overtime, or expense accounts.

If the Person is paid his annual gross income in less than 52 weeks, the Basic Weekly Earnings shall equal 1/52 of the annual gross income.

SECTION 2 - DEFINITIONS

CHILD(REN) means a minor related by blood, marriage or court order that can be claimed as a dependent for federal income tax purposes, such as:

- 1) natural born child(ren) of the Person;
- 2) legally adopted child(ren) of the Person from the time of placement in the Person's home and the filing of documents with the court to adopt;
- 3) stepchild(ren) who lives with the Person; and
- 4) child(ren) for whom the Person has legal guardianship.

COMPENSATORY TIME means time off with pay in lieu of overtime pay for regularly scheduled or irregular or occasional overtime work.

CONSUMER PRICE INDEX (CPI) means the statistical measure of the average change in prices figured by the United States Dept. of Labor, Bureau of Labor Statistics. The percent change in the Consumer Price Index for all Urban Consumers (CPI-U); U.S. City Average for All Items, for the prior calendar year will be used in calculations. If the CPI is discontinued or if its method of computation is significantly changed, AUL may use another comparable index.

COSMETIC SURGERY means surgery that is performed to change the texture, shape or structure of any part of the human body for the purpose of creating a different visual appearance.

COVERAGE MONTH means that period of time beginning on the Person's Individual Effective Date, and continuing from the first day and ending on the last day of each succeeding Policy Month.

CURRENT WEEKLY INCOME means the income a Person receives while Disabled, plus the income the Person could receive if he were working to his Maximum Capacity. Current Weekly Income does not include income from Salary Continuance.

If a Person is employed in a second job, at the same time he is Actively at Work as a Full-Time Employee for the Policyholder, and becomes Disabled under the policy, the following will apply during the Elimination Period and while receiving Disability benefits under the policy:

- 1) any income received from the second job will be considered Current Weekly Income only to the extent that it exceeds the average weekly income received from that job during the 6 month period immediately prior to becoming Disabled; and
- 2) if the Person has worked for the second employer less than 6 months, the income will be averaged for the total number of months he was employed.

If a Person receives Current Weekly Income in a Lump Sum, the Lump Sum Payment provision will apply.

SECTION 2 - DEFINITIONS

DATE OF DISABILITY means the first date the Person is Disabled.

DATE OF HIRE means the first day the Employee is Actively at Work in an eligible class for the Policyholder.

DISABILITY and DISABLED mean both Total Disability and Totally Disabled and Partial Disability and Partially Disabled.

DUE DATE means the first day of the Policy Month for which the premium is payable.

ELIGIBILITY DATE means the date that an Employee in an eligible class has satisfied his Waiting Period and AUL determines he is eligible for Personal Insurance under the policy.

ELIGIBLE SURVIVOR means:

- 1) the Person's legal Spouse; or
- 2) the Person's unmarried Child(ren) under the age of 26, if the Child(ren) can be claimed as a dependent on the Person's federal income tax return.

ELIMINATION PERIOD means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is set forth on the Schedule of Benefits and begins on the first day of Disability.

SECTION 2 - DEFINITIONS

EMPLOYEE means any individual who is a full-time employee (including owners, proprietors, partners, members or corporate officers) of the Policyholder:

- 1) whose employment with the Policyholder constitutes his principal occupation;
- 2) who works at that occupation a minimum number of hours as stated by the Policyholder in the Application;
- 3) who is working at the Policyholder's regular place of business which may include an alternative worksite if approved by the Policyholder and AUL;
- 4) who is not a part-time, temporary or seasonal Employee; and
- 5) who is authorized to work in the United States under applicable state and federal laws; or
- 6) if approved by AUL:
 - a) who legally works and resides in Canada;
 - b) who legally works in the United States and resides in Canada; or
 - c) who legally works in Canada and resides in the United States.

EMPLOYER means the entity or organization for which the Person performs services and which has the right to control what will be done. The Employer is the entity or organization for which the Person performs his occupation, and is required to withhold and pay income, Social Security, and Medicare taxes on wages.

EMPLOYER'S RETIREMENT PLAN means any defined benefit or defined contribution plan that provides retirement benefits to Employees and that is not funded wholly by Employee contributions. It includes any retirement plan that:

- 1) is part of any federal, state, county, municipal or association retirement system; and
- 2) that a Person is eligible for as a result of his employment with the Policyholder.

It does not include:

- 1) profit sharing plans;
- 2) thrift or savings plans;
- 3) Individual Retirement Accounts (IRAs) or Roth IRAs funded wholly by a Person's contributions;
- 4) Tax Sheltered Annuities (TSA);
- 5) Stock Ownership Plans (ESOP);
- 6) nonqualified deferred compensation plans, including 457 plans;
- 7) Keogh, 401(k) or 403(b) plans; or
- 8) Veteran Administration Benefits except benefits that are a result of the same Disability for which a Weekly Benefit is payable under the policy.

EVIDENCE OF INSURABILITY means a statement or proof of an Employee's medical history upon which eligibility for insurance will be determined by AUL.

SECTION 2 - DEFINITIONS

FAMILY SOCIAL SECURITY BENEFITS means benefits that a Person, his Spouse or Child(ren) are entitled to receive as a result of the Person's eligibility for disability insurance benefits or old age insurance benefits through the Federal Social Security Administration.

FAMILY STATUS CHANGE means an increase or decrease in coverage resulting from specific events occurring in a Person's life.

FRANCHISE COVERAGE means disability insurance coverage which allows Employees to be insured as part of their relationship with the Policyholder but such coverage is not part of an employee welfare benefit plan and the Employees are insured under individual policies.

GROSS WEEKLY BENEFIT means a Person's Weekly Benefit before any reduction for Other Income Benefits.

GUARANTEED ISSUE AMOUNT means the amount of coverage that does not require Evidence of Insurability. This amount is shown on the Schedule of Benefits page.

INDEXED PRE-DISABILITY EARNINGS means the Person's Pre-Disability Earnings increased annually by the Consumer Price Index, up to a maximum increase of 10%. The increase will be effective on the July 1st following the first 12 consecutive calendar months of receiving Disability benefits and on each subsequent July 1st.

INDIVIDUAL REINSTATEMENT means that Personal Insurance that has been terminated due to cessation of Active Work may be reinstated in accordance with Section 5A.

INJURY means a sudden, unforeseen and unexpected event that occurs independently of all other causes and causes physical harm to the Person. This includes all other conditions related to the same Injury.

MALE PRONOUN whenever used includes the female.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- 1) are normally required for the performance of an occupation; and
- 2) cannot be reasonably omitted or modified.

SECTION 2 - DEFINITIONS

MAXIMUM BENEFIT DURATION means the maximum amount of time that benefits will be payable for Disability. This amount of time is stated on the Schedule of Benefits.

MAXIMUM CAPACITY means, based on the Person's restrictions and limitations, the greatest extent of work the Person is able to do in his Regular Job.

MAXIMUM WEEKLY BENEFIT means the maximum amount of benefit payable to a Person on a weekly basis as stated on the Schedule of Benefits.

MEDICALLY NECESSARY means health care services that a Physician, exercising prudent clinical judgment, would provide to a Person for the purpose of evaluating, diagnosing or treating a Sickness or Injury, or its symptoms, and that are:

- 1) in accordance with the generally accepted standards of medical practice;
- 2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Person's Sickness or Injury; and
- 3) not primarily for the convenience of the Person or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Person's Sickness or Injury.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the *Diagnostic and Statistical Manual of Mental Health Disorders (DSM)*, published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the *DSM* is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability.

SECTION 2 - DEFINITIONS

OPTION means the benefits and provisions chosen on the Application by the Policyholder.

OPTION YEAR means a one-year period beginning on the Policyholder's Anniversary Date or on each subsequent anniversary of the Policyholder's Anniversary Date.

OTHER INCOME BENEFITS means those benefits listed below that the Person, his Spouse or Child(ren) are entitled to receive. It includes any benefit for which they are eligible, or that is paid to them or a Third Party on their behalf, including:

- 1) disability income benefits, including any damages or settlements made in place of such benefits (whether or not liability is admitted) under:
 - a) any automobile liability insurance or “no fault” motor vehicle plan, whichever is applicable;
 - b) a Third Party (after subtracting attorney’s fees) by judgment, settlement or otherwise not to exceed 50% of the net settlement;
 - c) state compulsory benefit law, including any state disability income benefit law or similar law;
 - d) disability benefits from the Veteran’s Administration, or any other foreign or domestic governmental agency, that begins *after* a Person becomes Disabled. This includes the amount of any increase in a benefit that a Person was receiving prior to becoming Disabled if the increase is attributed to the same disability for which the Person is currently receiving a Weekly Benefit under the policy; and
 - e) any other similar act or law;
- 2) any disability income benefit for which the Person is eligible under any other employee welfare benefit plan, or arrangement of coverage, whether insured or not, as a result of the Person’s employment with the Policyholder;
- 3) retirement and/or disability income benefits paid under an Employer’s Retirement Plan except for amounts attributable to a Person’s contributions;
- 4) any disability income or retirement benefit that has been received or is eligible to be received from:
 - a) the Social Security Administration or any similar law, plan or act, including the initial enactment and all amendments;
 - b) the Canada Pension Plan;
 - c) the Quebec Pension Plan;
 - d) the Railroad Retirement Act; or
 - e) any other state, provincial or local government act or law or any other similar act or law provided in any jurisdiction;
- 5) any amounts received from partnership or proprietorship draws or similar draws; and
- 6) any Current Weekly Income.

SECTION 2 - DEFINITIONS

The following items are NOT considered Other Income Benefits and will not be deducted from the Gross Weekly Benefit payable to the Person:

- 1) profit sharing plans;
- 2) thrift or savings plans;
- 3) Individual Retirement Accounts (IRA) or Roth IRAs funded wholly by a Person's contributions;
- 4) Tax Sheltered Annuities (TSA);
- 5) Stock Ownership Plans (ESOP);
- 6) nonqualified deferred compensation plans, including 457 plans;
- 7) Keogh, 401(k) or 403(b) plans;
- 8) Veteran Administration Benefits except those benefits that are a result of the same Disability for which a Weekly Benefit is payable under the policy;
- 9) credit disability insurance;
- 10) pension plans for partners;
- 11) individual disability policies paid for by the Person and not sponsored by the Policyholder;
- 12) Social Security Widow's benefits paid under the deceased Spouse's earnings record;
- 13) Social Security retirement income received by the Person if his disability begins after age 62 and he was already receiving Social Security retirement income payments;
- 14) Retirement plans from other employers; and
- 15) Salary Continuance Plans.

SECTION 2 - DEFINITIONS

PARTIAL DISABILITY and PARTIALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the Material and Substantial Duties of his Regular Job as a Full-Time Employee, but:

- 1) is performing at least one of the Material and Substantial Duties of his Regular Job, or another occupation, on a part or full-time basis;
- 2) his Current Weekly Income is less than 80% of his Indexed Pre-Disability Earnings due to the same Injury or Sickness that caused his Disability; and
- 3) he is under the Regular Attendance of a Physician for that Injury and Sickness.

Loss of occupational license for any reason does not in itself constitute Partial Disability.

PERSON means an Employee who has met the requirements of the Eligibility, Enrollment and Individual Effective Date of Insurance Sections of the policy.

PERSONAL INSURANCE means the insurance provided under the policy for an insured Person.

PHYSICIAN means a qualified, state licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, practicing within the scope of his license and applicable law. Physician does not include a Physician employed by the Policyholder, a Person or anyone related to a Person by blood, marriage, civil union, or domestic partnership.

SECTION 2 - DEFINITIONS

POLICYHOLDER means any sole proprietorship, partnership, member, corporation, limited liability company, limited liability partnership, firm, school district, individual school, union, association, organization or other instrumentality of a state or political subdivision thereof, that has been approved by AUL and to whom the policy is issued. An entity that is subsidiary to or affiliated with the Policyholder, as defined below is eligible for coverage under the policy if it is shown on the Application or later added by amendment to the policy.

A subsidiary may be included in this definition when the Policyholder owns more than 50% of the voting stock of the subsidiary corporation.

An affiliate may be included in this definition when the entity is under common control with the Policyholder through 51% or more ownership and control.

The Policyholder is liable for all premiums due for subsidiaries and affiliates during any period of time a subsidiary and/or affiliate is insured under the policy. Any notice given to the Policyholder by AUL shall be considered notice given to the subsidiary and/or affiliate.

POLICYHOLDER'S EFFECTIVE DATE means the date that coverage is actually effective for the Policyholder under the policy, as determined by AUL.

POLICYHOLDER'S ANNIVERSARY DATE means January 1st of each year.

PRE-DISABILITY EARNINGS means the Person's Basic Weekly Earnings in effect immediately prior to his Date of Disability, as last reported to AUL in writing by the Policyholder.

PRE-EXISTING CONDITION means any condition for which a Person has done any of the following at any time during the 3 months immediately prior to the Person's Individual Effective Date of Insurance, whether or not that condition was diagnosed at all or was misdiagnosed during that period of time:

- 1) received medical treatment or consultation;
- 2) taken or were prescribed drugs or medicine; or
- 3) received care or services, including diagnostic measures.

SECTION 2 - DEFINITIONS

PRIMARY SOCIAL SECURITY BENEFITS means benefits that the Person is entitled to receive for himself as a result of his eligibility for benefits through the Social Security Administration.

PRIOR PLAN means the Policyholder's plan of long or short term disability insurance, which terminated on the day immediately before the Policyholder's Effective Date of coverage under the policy.

REGULAR ATTENDANCE means that a Person:

- 1) personally visits a Physician as medically required according to standard medical practice, to effectively manage and treat the Person's Disability;
- 2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in his return to work; and
- 3) is receiving care by a Physician whose specialty or clinical experience is appropriate for the Disability.

SALARY CONTINUANCE means vacation pay, sick leave pay and/or paid time off pay, holiday pay and a documented formal salary continuation plan for Sickness or Injury received by a Person after his Date of Disability.

SICKNESS means illness, bodily disorder or disease, Mental Illness, normal pregnancy and Complications of Pregnancy. Complications of Pregnancy is defined as a concurrent disease or abnormal conditions significantly affecting the usual medical management of pregnancy.

SOCIAL SECURITY means the United States Social Security Act or any similar law, plan or act including the initial enactment and all amendments.

SPOUSE means:

- 1) an individual to whom the Person is legally married; or
- 2) the Person's civil union partner or domestic partner, as defined by applicable law.

Spouse does not include an individual from whom the Person is divorced or from whom the Person has dissolved a civil union or a domestic partnership.

SECTION 2 - DEFINITIONS

TERMINAL ILLNESS means a diagnosed illness that, according to generally accepted medical standards, is expected to result in death within 12 months.

THIRD PARTY means an individual, entity or an insurance company other than AUL.

TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness:

- 1) a Person cannot perform the Material and Substantial Duties of his Regular Job;
- 2) a Person is not working in any occupation; and
- 3) a Person is under the Regular Attendance of a Physician for that Injury or Sickness.

Loss of occupational license for any reason does not in itself constitute Total Disability.

WAITING PERIOD means the period of days, starting on the Date of Hire, that an Employee must be continuously Actively at Work while in an eligible class. The Waiting Period is stated in the Schedule of Benefits.

WEEKLY BENEFIT means the amount payable weekly by AUL to the Disabled Person. It is the Gross Weekly Benefits, reduced by Other Income Benefits.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

INITIAL EMPLOYEE means an Employee who is employed by the Policyholder before the Policyholder's Effective Date.

NEW EMPLOYEE means an Employee who is employed by the Policyholder on or after the Policyholder's Effective Date.

LATE ENROLLEE: A Late Enrollee is an Initial or New Employee who is Actively at Work, but does not request coverage during his Initial Enrollment Period. Enrollment after the Initial Enrollment Period can only be done during a Scheduled Enrollment Period and will not require satisfactory Evidence of Insurability.

ELIGIBILITY DATE: An Employee who is in an eligible class as stated in the Schedule of Benefits and has satisfied his Waiting Period, becomes eligible for Personal Insurance under the policy on:

- 1) *Initial Employee*: the later of:
 - a) the Policyholder's original Effective Date of coverage under the policy; or
 - b) the day immediately following completion of the Waiting Period.
- 2) *New Employee*: the first day of the Coverage Month immediately following completion of the Waiting Period.
- 3) *Late Enrollee*: the Policyholder's Anniversary Date following the next Scheduled Enrollment Period.

ENROLLMENT: To be considered for coverage, an eligible Employee must apply correctly and truthfully for Personal Insurance under the policy. Eligible Employees applying for Personal Insurance must complete and sign a request for coverage via an enrollment method approved by AUL within 31 days of their Eligibility Date and pay the required premiums before coverage will become effective. This form will be given to and maintained by the Policyholder. Coverage may only be requested as follows:

- 1) INITIAL ENROLLMENT PERIOD: The Initial Enrollment Period is the time during which an eligible Employee who is Actively at Work may first enroll for coverage following completion of the Waiting Period without providing Evidence of Insurability. An eligible Employee may waive coverage or request coverage under any Option offered by the Policyholder for his class. The Initial Enrollment Period includes the following periods, during which an Employee may make his initial application for coverage under the policy:
 - a) *Initial Employee*: the Initial Enrollment Period is the period of time agreed to by AUL and the Policyholder and is stated on the Schedule of Benefits; or
 - b) *New Employee*: the Initial Enrollment Period is the period that begins on the Eligibility Date and continues through the number of days as stated in the Schedule of Benefits; or
 - c) *Initial or New Employee not Actively at Work during his Initial Enrollment Period*: an Initial or New Employee not Actively at Work during his Initial Enrollment Period may enroll, without Evidence of Insurability, within 31 days from the date he returns to Active Work if:
 - i) he is in an eligible class as stated in the Schedule of Benefits; and
 - ii) his Waiting Period was completed prior to his cessation of Active Work.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

- 2) SCHEDULED ENROLLMENT PERIOD: This is a recurrent period of time starting after the Policyholder's original Effective Date, chosen by the Policyholder and approved by AUL, during which:
- a) an eligible Late Enrollee may apply for coverage under the policy via an enrollment method approved by AUL; or
 - b) an eligible Late Enrollee may apply, via an enrollment method approved by AUL, for a Weekly Benefit amount in excess of the Guaranteed Issue Amount for Late Enrollees as stated in the Schedule of Benefits with satisfactory Evidence of Insurability. See Section 4.

The Scheduled Enrollment Period is chosen by the Policyholder and must be approved by AUL.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

INDIVIDUAL EFFECTIVE DATE OF INSURANCE

Initial Employees:

- 1) The Individual Effective Date of Insurance for an eligible Initial Employee who has satisfied the Waiting Period prior to the Policyholder's original Effective Date is the Policyholder's original Effective Date under the policy as long as the Initial Employee:
 - a) requested coverage during the Initial Enrollment Period; and
 - b) is Actively at Work for the Policyholder on that date.
- 2) The Individual Effective Date of Insurance for an eligible Initial Employee who has not satisfied the Waiting Period prior to the Policyholder's original Effective Date is stated on the Schedule of Benefits and applies as long as the Initial Employee:
 - a) requested coverage during the Initial Enrollment Period; and
 - b) is Actively at Work for the Policyholder on that date.

New Employees: The Individual Effective Date of Insurance for an eligible New Employee is the date of the request if that date is the first day of a Coverage Month; otherwise it is the first day of the next Coverage Month as long as the New Employee:

- 1) requested coverage during the Initial Enrollment Period;
- 2) has completed the Waiting Period for New Employees; and
- 3) is Actively at Work on the Individual Effective Date of Insurance.

Initial or New Employee not Actively at Work during his Initial Enrollment Period: The date an Initial or New Employee returns to full-time Active Work will be his Individual Effective Date of Insurance, if he was enrolled during an Initial Enrollment Period, has completed the Waiting Period for Initial Employees, but was not Actively at Work on the date Personal Insurance would otherwise have become effective.

If enrolling after returning to Active Work, the Individual Effective Date of Insurance for an Initial or New Employee not Actively at Work is the first day of the Coverage Month following the Initial Enrollment Period.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

Late Enrollee: The Individual Effective Date of Insurance for an eligible Late Enrollee is the Policyholder's Anniversary Date following the Scheduled Enrollment Period as long as the Late Enrollee:

- 1) requested coverage during the Scheduled Enrollment Period;
- 2) has completed the Waiting Period for New Employees; and
- 3) is Actively at Work on the Individual Effective Date of Insurance.

COVERAGE IN EXCESS OF GUARANTEED ISSUE AMOUNT: The Individual Effective Date of Insurance as previously explained applies to any portion of the Maximum Weekly Benefit that does not exceed the Guaranteed Issue Amount. However, any portion of the Maximum Weekly Benefit that exceeds the Guaranteed Issue Amount will require Evidence of Insurability, satisfactory and without expense to AUL. If the excess portion is approved, the Effective Date of Insurance for that portion will be named by AUL. If the excess portion is not approved by AUL, the Maximum Weekly Benefit will be an amount equal to the Guaranteed Issue Amount.

Evidence of Insurability: Documentation and records are required to be forwarded to AUL, at no cost to AUL, if the request for coverage is made:

- 1) after an Employee's Initial Period;
- 2) after a Person's requested termination date; or
- 3) for coverage in excess of the Guaranteed Issue Amount.

If satisfactory Evidence of Insurability is provided, and coverage is approved in writing by AUL, the Individual Effective Date of Insurance will be named by AUL.

SECTION 4 - CHANGES IN INSURANCE

EFFECTIVE DATE OF CHANGE (First of the Coverage Month & No AIB)

A change in coverage that does not increase the amount of coverage becomes effective on:

- 1) the first day of the Coverage Month following AUL's approval of the change, if the date is the first day of the Coverage Month; or
- 2) the first day of the next Coverage Month following AUL's approval of the change, if the date is after the first day of the Coverage Month.

Prior to a change in coverage that increases the amount of coverage, the Person must be Actively at Work and the required amount of premium must be paid.

A change increasing the amount of coverage is subject to:

- 1) satisfactory Evidence of Insurability, at no expense to AUL; and
- 2) AUL's written approval.

If the Person is not Actively at Work on the approved change date, any change in the amount of coverage takes effect on the date the Person returns to Active Work.

If the change is an increase in coverage, see Pre-Existing Condition Exclusions in Section 9.

SECTION 4 - CHANGES IN INSURANCE

CHANGING OPTION: After the Initial Enrollment Period, a Person may increase his coverage to another Option available to his class during a Scheduled Enrollment Period as agreed to by the Policyholder and approved by AUL. The request for a change in Option and agreement to pay the required premium must be made via a method approved by AUL, subject to the following:

- 1) an increase in coverage to the next higher Option available to a Person's class will require Evidence of Insurability;
- 2) requests to increase coverage to an Option other than the next higher Option will not be allowed with satisfactory Evidence of Insurability; and
- 3) if a Person fails to apply for an increase in coverage in a manner agreed to by the Policyholder and approved by AUL, he will continue to be covered under his current Option until the next Scheduled Enrollment Period.

If the Person is not Actively at Work on the Effective Date of Change, the Person becomes eligible for the change on the first day that the Person returns to Active Work.

The provision entitled Pre-Existing Condition Exclusion For A Change In Option, shown in Section 9 - Exclusions, will apply to a change in Option resulting in an increase in coverage.

DECREASING THE WEEKLY BENEFIT AMOUNT: A Person may decrease the amount of his coverage at any time. Any decrease in coverage will become effective the first day of the Coverage Month following the date of the request.

Any change in insurance, other than a decrease in the amount of coverage or an increase in coverage to the next higher Option as stated above, will require satisfactory Evidence of Insurability.

If the change is an increase in coverage, see Pre-Existing Condition Exclusions in Section 9.

SECTION 4 - CHANGES IN INSURANCE

FAMILY STATUS CHANGE

A Person may request an additional amount of coverage or a Late Enrollee may request coverage, without Evidence of Insurability, up to the Guaranteed Issue Amount as stated in the Schedule of Benefits if all the following conditions are met:

- 1) The Person or Late Enrollee experienced one of the following changes in family status:
 - a) legal marriage;
 - b) domestic partnership or civil union, as defined under applicable laws in the state of residence of the Person;
 - c) divorce or dissolution of a domestic partnership or civil union;
 - d) birth of a child;
 - e) adoption of a child or stepchild; or
 - f) permanent legal custody or guardianship of a child lasting more than 90 days;
- 2) AUL was notified within 31 days of the change in family status;
- 3) the Person or Late Enrollee was Actively at Work on the effective date of the change;
- 4) the amount of coverage after the increase is not greater than the Weekly Benefit amount stated in the Schedule of Benefits; and
- 5) the Person or Late Enrollee has not previously been declined.

This change will become effective the first day of the Coverage Month following the date of the request.

If coverage for a Person or Late Enrollee was previously declined due to unsatisfactory Evidence of Insurability, no Family Status Change will be approved until Evidence of Insurability satisfactory to AUL is received. If the Person's or Late Enrollee's Family Status Change request is approved, coverage will begin on the date identified in writing by AUL.

SECTION 5 - TERMINATIONS

INDIVIDUAL TERMINATIONS: A Person will cease to be insured on the EARLIEST of the following dates:

- 1) the date the policy terminates;
- 2) the date the Person is no longer in an eligible class;
- 3) the date the Person's class, as stated on the Schedule of Benefits, is no longer insured under the policy;
- 4) the last day of the period for which premiums were paid, if the premium is not paid when due;
- 5) the date the Person requests termination, but not prior to the date of the request;
- 6) the date employment terminates. However, insurance will be continued for a Person:
 - a) during the Elimination Period, if the Person is Disabled, as described in the policy;
 - b) during any period that premiums are being waived under the Waiver of Premium provision;
 - c) during any temporary Leave of Absence according to the appropriate Continuation of Personal Insurance benefit if premiums continue to be paid during the Leave of Absence, and the benefit was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL;
 - d) to the end of the Coverage Month following the month that a Person is temporarily laid off as long as premiums continue to be paid, if coverage during a temporary layoff was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL; and
- 7) the date the Person ceases Active Work. However, insurance will be continued for a Person:
 - a) during the Elimination Period, if the Person is Disabled, as described in the policy;
 - b) during any period that premiums are being waived under the Waiver of Premium provision;
 - c) during any temporary Leave of Absence according to the appropriate Continuation of Personal Insurance benefit if premiums continue to be paid during the Leave of Absence, and the benefit was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL; and
 - d) to the end of the Coverage Month following the month that a Person is temporarily laid off as long as premiums continue to be paid, if coverage during a temporary layoff was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL.

SECTION 5 - TERMINATIONS

TERMINATION OF THE POLICY: Insurance coverage under the policy will cease on the EARLIEST of the following dates:

- 1) the date the Policyholder no longer meets the definition of a Policyholder;
- 2) the date the Policyholder ceases active business operations or is placed in bankruptcy or receivership;
- 3) the date the Policyholder loses its entity by means of dissolution, merger, or otherwise;
- 4) the date ending the Policy Month for which the last premium payment is made for the Policyholder's insurance;
- 5) at the end of a Policy Month, provided AUL has given at least 31 days prior written notice to the Policyholder;
- 6) at the end of the Policy Month, if the Policyholder has given AUL at least 31 days prior written notice;
- 7) the date, as determined by AUL, that the Policyholder fails to promptly furnish any information which AUL may reasonably require; or
- 8) the date the Policyholder, without good and sufficient cause, fails to perform in good faith its duties pertaining to the policy.

If a Person's insurance is terminated due to the termination of the policy, the Person's rights under the policy are terminated on the date that the policy terminated.

Termination of the policy under any conditions will be without prejudice to any claim incurred prior to termination.

If the policy terminates, the Policyholder will be liable to AUL for all unpaid premiums for the period during which the coverage was in force.

SECTION 5 - TERMINATIONS

EXTENDED BENEFIT: If the Person is Disabled on the date insurance terminates, AUL will pay benefits for Disability:

- 1) after the Elimination Period has been met, if the Person is not already receiving a Weekly Benefit;
- 2) during the uninterrupted continuance of the same period of Disability; and
- 3) subject to the provisions and benefits of the policy.

Benefits will be extended to the EARLIEST of the following:

- 1) the date Current Weekly Income equals or exceeds 80% of the Indexed Pre-Disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration, shown on the Schedule of Benefits, is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide information to AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive weeks of benefits.

SECTION 5A - INDIVIDUAL REINSTATEMENT

INDIVIDUAL REINSTATEMENT: If Personal Insurance terminates under the policy due to cessation of Active Work for the Policyholder, it may be reinstated subject to the terms of this provision. Individual Reinstatement must be requested during the 31-day period immediately following return to Active Work for the Policyholder in accordance with the terms stated in this provision. Individual Reinstatement will be for the same coverage amount and eligible class that the Employee belonged to immediately prior to his termination. AUL may require Evidence of Insurability if reinstatement is requested for an amount or eligible class that differs from the coverage the Employee had with the Policyholder immediately prior to his cessation of Active Work. Reinstatement is subject to payment of required premiums and that the Policyholder is insured by AUL under the policy. In addition to the above requirements, the following also applies, as applicable:

- 1) If an Employee returns to Active Work within the period of consecutive calendar days as stated in the Schedule of Benefits under Individual Reinstatement from his individual termination date and requests Individual Reinstatement:
 - a) Personal Insurance will become effective the first day of the Coverage Month immediately following the date of request for Individual Reinstatement.
 - b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Employee under the policy immediately prior to cessation of Active Work.
 - c) *If the Schedule of Benefits states that the Employee must return to Active Work within 30 days of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period and of the Pre-Existing Condition exclusion or limitation period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the eligibility Waiting Period and the Pre-Existing Condition exclusion or limitation period.
 - d) *If the Schedule of Benefits states that the Employee can return to Active Work for a period greater than 30 days from the Employee's date of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The Employee will be considered a New Employee and subject to the terms of the policy, except as stated herein.
- 2) If an Employee returns to Active Work after more than the number of consecutive calendar days, shown in 1) above, after his Individual Termination date and requests Individual Reinstatement:
 - a) The Employee will be considered a New Employee and subject to the terms of the policy.
 - b) Eligibility for Personal Insurance, enrollment and his Individual Effective Date of Insurance will be determined as stated in the policy.
 - c) The Waiting Period and Pre-Existing Condition exclusion or limitation period will start anew. The Individual Reinstatement date will be used when applying the Pre-Existing Condition exclusion or limitation period.
- 3) If the Employee is insured under the policy's Portability Privilege and returns to Active Work with the Policyholder and requests Individual Reinstatement to the policy.
 - a) Personal Insurance will become effective the first day of the Coverage Month immediately following the date of request for Individual Reinstatement.
 - b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Employee under the policy immediately prior to cessation of Active Work.
 - c) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period already served under the policy and the Portability Privilege. The Employee's original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
 - d) Coverage under the Portability Privilege must terminate immediately prior to the date of Individual Reinstatement under the policy.

SECTION 5A - INDIVIDUAL REINSTATEMENT

- 4) If Personal Insurance terminates because of a leave approved by the Policyholder under the Federal Family and Medical Leave Act (FMLA), or similar applicable state law, and the Employee returns to full-time Active Work immediately following the end of the leave:
 - a) Personal Insurance will become effective immediately upon the date of request for Individual Reinstatement.
 - b) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period previously served under the policy. However, the days accumulated during the period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
 - c) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class that the Employee would have been entitled to prior to the FMLA leave.
- 5) If Personal Insurance terminates because an Employee became a full-time member of the armed forces of the United States and he returns to full-time Active Work, the Person's coverage may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law.

**SECTION 5B - CONTINUATION OF PERSONAL INSURANCE
UNDER THE FAMILY AND MEDICAL LEAVE ACT**

CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT. If the Policyholder correctly approves a leave of absence under the Federal Family and Medical Leave Act (FMLA), a Person's coverage under the policy will be continued as stated in this Section. Personal Insurance will continue while a Person's leave is covered under FMLA, until the end of the later of:

- 1) the leave period permitted under FMLA or
- 2) the leave period permitted by applicable state law.

Coverage continued under this Section is subject to the following requirements:

- 1) the Policyholder has approved a Person's leave in writing as a leave taken under FMLA;
- 2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 - PREMIUM PAYMENT); and
- 3) Basic Weekly Earnings will be the amount as last reported to AUL in writing and in effect prior to the date the Person's family or medical leave began.

Continuation of Personal Insurance under this provision will cease on the earliest of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

**SECTION 5C - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF**

LEAVE OF ABSENCE references in this Section means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance and in writing by the Policyholder and includes temporary layoffs unless otherwise stated.

CONTINUATION OF PERSONAL INSURANCE WHILE TEMPORARILY LAID OFF. If the Policyholder approves a temporary layoff, a Person's coverage under the policy will be continued to the end of the Coverage Month following the month in which the layoff begins, as long as premiums continue to be paid to and received by AUL, subject to same requirement as a Leave Of Absence.

CONTINUATION OF PERSONAL INSURANCE UNDER A LEAVE OF ABSENCE: If the Policyholder approves a Leave of Absence, a Person's coverage under the policy will be continued to the end of the Coverage Month following the month that a Person begins a Leave of Absence as long as premiums continue to be paid to and received by AUL, subject to the following requirements:

- 1) the Policyholder has approved a Person's Leave of Absence in writing;
- 2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 – PREMIUM PAYMENT); and
- 3) Basic Weekly Earnings will be the amount last reported to AUL in writing and in effect prior to the date the Person's Leave of Absence began.

Continuation of Personal Insurance under this provision will cease on the EARLIEST of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

**SECTION 5C - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF**

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

**SECTION 5D - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE**

LEAVE OF ABSENCE means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance in writing by the Policyholder.

CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE: If the Person is on a Leave of Absence for Active Military Service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law, the Person's coverage may be continued until the LATER of:

- 1) the length of time the coverage may be continued under the policy for an FMLA leave of absence; or
- 2) the length of time the coverage may be continued under the policy for a Leave of Absence other than an FMLA leave of absence.

Coverage continued under this Section is subject to the following requirements:

- 1) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 - Premium Payment); and
- 2) Basic Weekly Earnings will be the amount last reported to AUL in writing and in effect prior to the date the Person's Leave of Absence for Active Military Service began.

Continuation of Personal Insurance under this provision will cease on the earliest of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

SECTION 6 - PREMIUM PAYMENT

PREMIUM PAYMENTS: As provided in the Application, the Policyholder is responsible for properly and accurately paying premiums to AUL on or before the Due Date. All premiums will be calculated and paid in U.S. dollars. At the request of the Policyholder and AUL's written approval, the interval of premium payments may be changed.

Overpayment of premium will not result in increases in any coverage amounts or additional benefits for the Policyholder or Person. If a Person has contributory insurance, premiums paid by the Person may be paid by means of payroll deduction administered by the Policyholder.

Premiums for a Person's coverage under the policy shall be owed beginning on the Person's Individual Effective Date of Insurance. Premiums will cease to be owed on the Person's individual termination date. However, premiums will continue to be owed for a Disabled Person who ceases work. Premiums will continue to be owed until the date they are waived according to the Waiver of Premium provision.

Monthly premiums for each Person will change automatically following attainment of each new age bracket. Each premium payment will include adjustments in past premiums for changes that have not previously been taken into account. Payment of any premium does not maintain the insurance in force beyond the end of the period for which it has been paid. Each premium payment is owed to AUL on or before its Due Date.

PREMIUM RATES: AUL reserves the right to change premium rates on any date:

- 1) after the Policyholder's coverage has been in effect for one year, by giving prior written notice to the Policyholder at least 31 days before the effective date of the change;
- 2) the eligibility or benefit provisions are changed;
- 3) the number of Persons insured through the Policyholder changes by 25% or more;
- 4) a division, unit, subsidiary or affiliate is added to, or deleted from, the Policyholder's coverage under the policy;
- 5) if the age or any other fact that affects the benefits for a Person or Policyholder has been misstated; or
- 6) there is a change in existing laws which affects the coverage offered under the policy.

WAIVER OF PREMIUM: Premium payments will be waived for a Disabled Person beginning with the first day of Disability. Premiums will continue to be waived during any period that benefits are paid to a Person insured by the policy or any AUL Group Long Term or Short Term Disability Income policy if those policies were made available to the Person through employment with the Policyholder. Premiums for coverage under the policy will be waived as described in this provision, provided the Disability claim is approved by AUL. If a Disabled Person returns to work before the end of his Elimination Period or his Benefit Eligibility Period, his premium payments will resume, but he will not be required to repay the waived premiums.

SECTION 7 - GENERAL POLICY PROVISIONS

AGENCY: For all purposes of the policy, the Policyholder acts on behalf of itself or as agent for the Person. Under no circumstances will the Policyholder be deemed the agent of AUL.

AMENDMENT AND CHANGES: The policy may be amended in writing by mutual agreement between the Policyholder and AUL, but without prejudice to any loss incurred prior to the effective date of the amendment. No change in the policy is valid until approved by the Chief Executive Officer, President or Secretary of AUL. No agent has the authority to approve coverage, change the policy or waive any of its provisions.

ASSIGNMENT: No assignment of any present or future right or benefit under the policy will bind AUL without its prior written consent and when permitted under applicable laws.

CERTIFICATES: AUL will issue a certificate for delivery by the Policyholder to the insured Persons. The certificate will summarize the Person's coverage under the policy and will state:

- 1) the benefits provided; and
- 2) to whom the benefits are payable.

If there is any discrepancy between the provisions of any marketing materials, plan documents, certificate, and the provisions of the policy, the provisions of the policy will govern.

CLERICAL ERROR: If a clerical error is made in keeping records on the coverage under the policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise terminated, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy.

CONFORMITY WITH STATE LAWS: Any provision of the policy in conflict with the laws of the state in which it is delivered, is amended to conform to the minimum requirements of those laws.

DATA AND RECORDS: The Policyholder must promptly furnish all information/documentation that AUL reasonably requires. The Policyholder must furnish all relevant information to AUL about Persons:

- 1) who qualify to become insured or are eligible for benefits; and/or
- 2) whose amounts of insurance change; and/or
- 3) whose insurance terminates.

At any reasonable time, AUL or its representatives shall have the right to inspect the records of the Policyholder that, in the opinion of AUL, may have a bearing on the insurance coverage provided under the policy.

SECTION 7 - GENERAL POLICY PROVISIONS

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if AUL (or its third party administrator) decides in its discretion that the Person is entitled to them. Except for the functions the policy explicitly reserves to the Policyholder, AUL (or its third party administrator) reserves the right to:

- 1) manage the policy and administer claims under it; and
- 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:

- 1) establish and enforce procedures for administering the policy and claims under it;
- 2) determine Employees' eligibility for coverage and entitlement to benefits;
- 3) determine what information it reasonably requires to make such decisions; and
- 4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator.

ENTIRE CONTRACT: The policy, the application/enrollment forms of the Persons, the Application of the Policyholder, and any amendments made from time to time constitute the entire contract.

GRACE PERIOD: If the Policyholder or AUL does not give notice in writing that coverage under the policy is to be terminated due to unpaid premium, a Grace Period of 31 days will be granted for the payment of any premium owed after the first premium Due Date. During the Grace Period, the policy will continue in force but will automatically terminate on the last day of the Grace Period. The Policyholder is liable to AUL for payment of premiums for the days of grace during which the policy remains in force. AUL is not obligated to pay claims incurred during the Grace Period until the premium owed is received.

INSURANCE FRAUD: AUL wants to ensure that its customers do not incur additional insurance costs as a result of the act of insurance fraud. Applicable state laws require AUL to undertake measures to detect, investigate and pursue prosecution for fraud.

Anyone that knowingly completes an application for insurance or statement of claim containing any materially false information or facts, with the intent to deceive, conceal or mislead is committing a fraudulent insurance act. This is a crime and may subject such Persons to criminal and civil penalties.

MISSTATEMENT OF FACTS: If the age or any other fact that affects the benefits for a Person or Policyholder has been misstated, the benefits will be payable based on the true facts. Premium adjustment will be made so that AUL will receive the actual premium required based on the true facts.

SECTION 7 - GENERAL POLICY PROVISIONS

REHABILITATION: The goal of a rehabilitation program is to enable the Person to return to work. The Person may choose to join a vocational rehabilitative program while receiving Disability benefits, if prior approval is given in writing by AUL. If the program is approved in advance by AUL, such participation will not alone be deemed recovery from Disability. By mutual written agreement, AUL may help pay the Person's expenses for taking part in the rehabilitation program. Rehabilitation is strictly voluntary and there is no penalty for refusal.

RELATIONSHIP: AUL and the Policyholder are, and will remain, independent contractors. Nothing in the policy or the Application shall be construed as making the parties joint venturers or as creating a relationship of employer and employee, master and servant or principal and agent. Neither party has any power, right or authority to bind the other or to assume or create any obligation or responsibility on behalf of the other. AUL and the Policyholders each retain exclusive control of their time and methods to perform their respective duties. AUL and the Policyholder will employ, pay and supervise their own employees and pay their own expenses. The Policyholder is required to familiarize itself with all relevant state and federal laws including applicable banking, MEWA, plan sponsor, plan administrator, and fiduciary laws. Any violation of federal or state law will require Policyholder to reimburse AUL for any and all damages or fines imposed on AUL as well as AUL's reasonable attorney's fees incurred due to Policyholder's violations and/or any violations incurred by any representative of Policyholder, in which AUL is made party thereof.

STATEMENTS MADE IN AN APPLICATION: all statements in an application or Group Statement of Insurability made by the Policyholder or insured Persons shall be deemed representations and not warranties. No such statements will be used to reduce or deny any claim or to cancel the Person's coverage unless:

- 1) the statement is in writing; and
- 2) a copy of that statement is given to the Person or to his personal representative.

INCONTESTABILITY: The validity of any coverage under the policy may not be contested, except in the case of fraud or for nonpayment of premiums, after the Personal Insurance has been in force for 2 years from the Person's Individual Effective Date of Insurance. Additionally, if the validity of any coverage under the policy is contested due to a misrepresentation of a material fact during the first 2 years after the Person's Individual Effective Date of Insurance, no statement made by a Policyholder or a Person relating to his insurability may be used in contesting the validity of the insurance unless the statement is contained in a written instrument signed by the Person.

All statements made by a Policyholder or a Person are to be deemed representations and not warranties, and that other than a misrepresentation of a material fact no statement made by any Person may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Person or, in the event of death or incapacity of the Person, to the Person's personal representative.

Notwithstanding the foregoing, AUL is not precluded from asserting at any time any defenses based upon provisions in the policy relating to eligibility for coverage.

WORKERS' COMPENSATION AND WORKMEN'S COMPENSATION NOT AFFECTED: The policy is not in lieu of, and does not affect any requirement for coverage by Workers' or Workmen's Compensation Insurance.

SECTION 7A - CLAIM PROCEDURES

INITIAL NOTICE OF DISABILITY: Written notice of Disability must be given to AUL during the Elimination Period. If written notice cannot be made during the Elimination Period without the fault of the claimant, AUL must be notified as soon as it is reasonably possible to do so. Written notice should contain sufficient information to identify the Person. Notices are not considered given until received by AUL at its Home Office in Indianapolis, Indiana, by one of its Claims offices, or by its third party administrator.

CLAIM FORMS FOR PROOF OF LOSS: Upon receipt of the Initial Notice of Disability, AUL will furnish the Policyholder with any necessary claim forms to be given to the Person. These forms must be properly, accurately and truthfully completed and returned to AUL or its third party administrator. If, for any reason, the Person does not receive a claim form within 15 days of request, the Person should submit written proof of Disability. The initial claim form or proof of Disability must show:

- 1) the claimant's name;
- 2) the Employer's name and address;
- 3) the policy number;
- 4) the date Disability started;
- 5) the cause of Disability;
- 6) the nature and extent of the Disability;
- 7) that the claimant is under the appropriate care of a doctor;
- 8) the appropriate documentation of the claimant's earnings and activities; and
- 9) the name and address of any hospital, health provider, health facility or institution where the claimant has received treatment, including the names of all attending and treating doctors.

The initial claim form or proof of Disability must be signed by a Physician and sent to AUL within 90 calendar days of the end of the Elimination Period. If it is not possible to give proof within these limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required.

AUL will also periodically send the Person additional claim forms or requests for information necessary to determine eligibility for benefits under the policy. These subsequent completed claim forms and requests for information must be returned to AUL within 30 days after the Person receives them. If requested forms and/or information are not received from the Person, AUL reserves the right to deny continued benefits for failure to provide proof of continuous disability as required by the policy.

PHYSICAL EXAMINATION: AUL, at its own expense, has the right to have a Person examined, hospitalized and/or tested to determine the existence of any Disability that is the basis for a claim. This right may be exercised as often as is reasonably necessary, as determined by AUL, and must be performed by a Physician of AUL's choice. If the Person fails to comply with AUL's requests for Physical Examination, AUL reserves the right to deny benefits.

SECTION 7A - CLAIM PROCEDURES

LEGAL ACTION: No legal action may be brought to obtain benefits or a refund of premium paid under the policy:

- 1) for at least 60 days after proof of loss or entitlement to a premium refund has been furnished;
- 2) before any denial or reduction of benefits by AUL has been appealed properly in writing; or
- 3) beyond the expiration of the applicable statute of limitations from the time proof of loss or entitlement to a premium refund is required to be given. If no statute of limitations is given, then after 3 years following the expiration of the time within which proof of loss or entitlement to a premium refund is required by the Policyholder.

TIME OF PAYMENT OF CLAIMS: When AUL receives a claim form or proof of Disability, benefits payable under the policy will be paid weekly during any period for which AUL is liable.

PAYMENT OF CLAIMS: All benefits, other than any survivor benefits, are payable to a Person. If a Person dies before a benefit to which he was entitled is paid, AUL has the right to pay up to \$10,000 to any of the Person's relatives to whom AUL considers entitled to such benefits. If AUL pays benefits in good faith to a person who it considers entitled to such benefits, then AUL will have no obligation to pay such benefits again. The Weekly Benefit will be calculated and paid in United States dollars, and when necessary, it will be based on the exchange rate effective on the first day of the Elimination Period.

SECTION 7A - CLAIM PROCEDURES

RIGHT TO APPEAL: When the policy is governed by ERISA, if a Person wishes to appeal the decision made by AUL or its third party administrator, claimants are allowed 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants are allowed the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. 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. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of 29 C.F.R. § 2560.503-1. AUL's review will take into account all written 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 benefit determination. A claimant has a right to obtain the information about any voluntary appeal procedures offered by the plan described in paragraph (c)(3)(iv) of 29 C.F.R. § 2560.503-1 and has a right to bring an action under section 502(a) of ERISA. A final determination will be provided pursuant to 29 C.F.R. § 2560.503-1.

RIGHT OF RECOVERY: If benefits have been received for which the Person was not entitled to receive under the policy, then full reimbursement to AUL is required. Such reimbursement is required whether the overpayment is due to intentional or innocent misrepresentations by the Person, intentional or innocent misrepresentations by an entity supplying AUL with information, a claims processing error or miscalculation by AUL or for any other reason. If reimbursement is not made, then AUL has the right, as allowed under law to:

- 1) reduce future benefits or any amounts payable under all other AUL insurance contracts insuring the Person until full reimbursement is made, and
- 2) recover such overpayments from the Person or his estate.

If AUL chooses not to use benefit payments towards the reimbursement, this will not constitute a waiver of AUL's rights to reimbursement. This provision will be in addition to, and not in lieu of, any other compensation available to AUL by law.

SUBROGATION RIGHTS: AUL has the right to be subrogated to any rights a Person may have against a Third Party. AUL may, at its option, bring legal action to recover benefits it paid in connection with a Person's Disability. AUL may do this if a Person:

- 1) suffers a Disability and, because of any act or omission of a Third Party, becomes entitled to and is paid benefits under the policy; and
- 2) does not initiate legal action for the recovery of such benefits from the Third Party within a reasonable period of time.

SECTION 8 - INSURING PROVISIONS

WEEKLY BENEFIT PAYMENTS: AUL will pay Disability benefits, according to the policy, if a Person becomes Disabled while insured by the policy. AUL must receive proof that a Person is Disabled due to Sickness or Injury and requires the Regular Attendance of a legally qualified Physician. AUL will pay the Person a Weekly Benefit after the Person satisfies the Elimination Period. The Elimination Period may be satisfied by Total Disability, Partial Disability, or a combination of both.

The Weekly Benefit will be paid as long as Disability continues; provided that proof of continued Disability is submitted to AUL upon request and the Person is under the Regular Attendance and care of a Physician. The proof must be submitted at the Person's expense. Weekly Benefits will not be paid during any period that a Person is incarcerated in a penal or correctional institution.

The Weekly Benefit will not exceed the Maximum Weekly Benefit, nor will it be payable for longer than the Maximum Benefit Duration. The Maximum Weekly Benefit and the Maximum Benefit Duration are stated in the Schedule of Benefits.

PRORATING OF THE WEEKLY BENEFIT: The eligible Weekly Benefit will be paid on a weekly basis. For any period of Disability less than one week, the Weekly Benefit payment will be paid on a pro-rata basis at the rate of 1/7 per day.

REDUCTIONS TO THE WEEKLY BENEFIT: Other Income Benefits will reduce the Weekly Benefit as defined in this certificate. The Social Security Integration Method used is stated in the Schedule of Benefits.

SECTION 8 - INSURING PROVISIONS

WEEKLY BENEFITS: To figure the amount of the Total Disability Benefit if a Direct Primary or Family Social Security integration method is stated on the Schedule of Benefits, take the Person's Weekly Benefit and reduce the result by Other Income Benefits.

SECTION 8 - INSURING PROVISIONS

LUMP SUM PAYMENTS: Other Income Benefits that are paid in a lump sum, excluding benefits received from the Employer's Retirement Plan, will be prorated by AUL over the stated period of time the lump sum was projected to apply. Lump sums projected to cover the Person's life expectancy will be prorated based on appropriate actuarial tables. If the projected period of time that a lump sum is intended to cover is not stated, the lump sum will be prorated over a period of 60 months.

A lump sum payment from an Employer's Retirement Plan will be prorated over 60 months. However, if such lump sum is rolled to an annuity or retirement account that does not pay a benefit prior to the end of the Maximum Benefit Duration stated in the Schedule of Benefits, then the Gross Monthly Benefit will not be reduced by that lump sum payment.

Regardless of how benefits from the Employer's Retirement Plan are distributed, AUL will treat contributions made by the Person and Policyholder as if they were distributed simultaneously throughout the Person's lifetime.

APPLICATION FOR OTHER INCOME BENEFITS: If the Person, Spouse or Child(ren) are or become eligible for any Other Income Benefit, they must:

- 1) apply for the Other Income Benefits; and
- 2) appeal any denial for the Other Income Benefits that appears unreasonable.

Until approval or denial of any Other Income Benefits for any Disability is determined, AUL will make payments as indicated below.

AUL will pay the Weekly Benefit after the Elimination Period, with no reduction for estimated benefits until the appropriate entity has reached a decision. When a decision is reached, the Person must send AUL a copy of the determination and reimburse AUL for any overpayment made as a result of that decision, regardless of whether or not the coverage is still in force on the date the Person recovers such amount.

Additionally, if an award is made, AUL will reduce the Weekly Benefit by the amount of the Other Income Benefits the Person received, in accordance with the terms of the policy.

SECTION 8 - INSURING PROVISIONS

SOCIAL SECURITY APPLICATION ASSISTANCE. When AUL determines that a Person is a likely candidate for Social Security Disability Insurance (SSDI), AUL may assist the Person with the application process for these benefits.

Upon written request, a representative from AUL's Group Claims Department may supply pertinent information to the Person about:

- 1) eligibility for SSDI benefits;
- 2) how to begin the application process;
- 3) how to submit an appeal;
- 4) guidelines established by the Social Security Administration for submitting appeals; and
- 5) names of organizations offering assistance.

SECTION 8 - INSURING PROVISIONS

MINIMUM WEEKLY BENEFIT: While a Weekly Benefit is payable under the policy, the Weekly Benefit shall not be reduced to an amount less than the Minimum Weekly Benefit indicated in the Schedule of Benefits.

COST OF LIVING ADJUSTMENT FREEZE: If the Person receives a cost of living increase, with regard to Other Income Benefits, after the date benefits actually become payable under the policy, the Weekly Benefit will not be further reduced by such cost of living increase. For purposes of this provision, a cost of living increase is any annual increase reasonably related to the annual increase in any generally recognized cost of living measurement that applies to all Persons who are entitled to receive such benefits.

TERMINATION OF THE WEEKLY BENEFIT: The Weekly Benefit will cease on the EARLIEST of the following:

- 1) the date Current Weekly Income equals or exceeds 80% of the Indexed Pre-disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration stated in the Schedule of Benefits is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive Weekly Benefit payments.

SECTION 8 - INSURING PROVISIONS

RESIDUAL BENEFIT: If the residual benefit is elected by the Policyholder, then the Elimination Period can be met using Total Disability, Partial Disability, or a combination of both.

RECURRENT DISABILITY: If, after a period of Disability for which benefits are payable, the Person resumes his Regular Job as a Full-Time Employee and performs each Material and Substantial Duty of that Job for 30 consecutive days of full-time work, any Recurrent Disability will be part of a new period of Disability and a new Elimination Period must be completed before any further Weekly Benefits are payable.

If the Person resumes his Regular Job as a Full-Time Employee and performs each Material and Substantial Duty of that Job for less than 30 consecutive days of full-time work, a Recurrent Disability will be part of the same period of Disability. The Recurrent Disability must be the direct result of the Injury or Sickness that caused the prior Disability. The Person will not have to complete a new Elimination Period. Benefit payments will be subject to the terms of the policy for the prior Disability. The benefit will be based on the amount of Basic Weekly Earnings in effect immediately prior to the original Elimination Period.

In order to prevent over-insurance because of duplication of benefits, benefits payable under the Recurrent Disability provision will cease if benefits are payable to the Person under any other group short term disability policy.

The Recurrent Disability provision in this Section is only applicable as long as the Policyholder's coverage remains in force with AUL.

SECTION 8 - INSURING PROVISIONS

PRESUMPTIVE DISABILITY: When a Person is Partially Disabled and his Current Weekly Income is 20% or less than his Indexed Pre-Disability Earnings, AUL will not reduce the Weekly Benefit by Current Weekly Income.

BENEFITS WHILE PARTIALLY DISABLED: When proof is received that a Person is Partially Disabled, then the Partial Disability Benefit applies. Benefits are payable following completion of the Elimination Period. The Partial Disability must be the direct result of the Injury or Sickness that caused the Disability immediately preceding it.

SECTION 8 - INSURING PROVISIONS

PARTIAL DISABILITY BENEFIT: The benefit for Partial Disability will be calculated as follows:

- 1) Subtract the Person's Current Weekly Income from the Person's Indexed Pre-Disability Earnings.
- 2) Divide the answer in Item 1) by the Person's Indexed Pre-Disability Earnings. The result is the Person's percentage of lost earnings.
- 3) From the Person's Gross Weekly Benefit, subtract any Other Income Benefits;
- 4) Multiply the answer in Item 2) by the answer in Item 3). This is the Person's benefit for Partial Disability.

Benefits for Partial Disability will never exceed the Person's Maximum Weekly Benefit as shown on the Schedule of Benefits, nor be less than the Minimum Weekly Benefit as shown on the Schedule of Benefits. The Partial Disability Benefit will continue as shown above until the EARLIEST of the date:

- 1) the Person ceases to be Partially Disabled;
- 2) the Person dies;
- 3) the Maximum Benefit Duration, as shown on the Schedule of Benefits, is completed;
- 4) the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 5) the Person refuses to allow an examination requested by AUL;
- 6) the Person is no longer under the Regular Attendance and care of a Physician;
- 7) the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 8) the Person leaves the United States or Canada and establishes his residence in another country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive weeks of benefits.

For purposes of the Partial Disability Benefit provision, Pre-Disability Earnings will be increased annually using the Consumer Price Index. The increase will be effective on the July 1st following the first 12 consecutive calendar months of Disability and on each subsequent July 1st. The annual increase is only to determine eligibility and will not increase the Partial Disability Benefit.

AUL may require any evidence needed to verify the Person's earnings and proof of continuing Disability.

SECTION 8 - INSURING PROVISIONS

ORGAN TRANSPLANT PROCEDURE means the surgical removal of any one or more of a Person's organs for the purpose of transplanting to another individual.

ORGAN DONOR TRANSPLANT BENEFIT: AUL will pay a Weekly Benefit if a Person becomes Disabled as a result of an Organ Transplant Procedure while insured under the policy. Proof of the Disability must be received by AUL for review. Payment of this benefit will not be subject to satisfaction of the Pre-Existing Condition exclusion or limitation period.

TERMINATION: The Organ Donor Transplant Benefit will terminate the EARLIER of:

- 1) the date Current Weekly Income equals or exceed 80% of the Indexed Pre-disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration stated in the Schedule of Benefits is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive Weekly Benefit payments.

SECTION 9 - EXCLUSIONS

GENERAL EXCLUSIONS: The policy does not cover any Disability caused by, contributed to by, or resulting from:

- 1) participation in war or any act of war, declared or undeclared;
- 2) active participation in a riot;
- 3) attempted suicide, regardless of mental capacity;
- 4) attempted or actual self-inflicted bodily injury or self destruction, including but not limited to the voluntary inhaling or taking of:
 - a) a prescription drug in a manner other than as prescribed by a Physician;
 - b) any federal or state regulated substance in an unlawful manner;
 - c) non-prescription medicine in a manner other than as indicated in the printed instructions;
 - d) poison; and
 - e) toxic fumes;
- 5) commission of or attempt to commit a criminal act under relevant state law;
- 6) Cosmetic Surgery. However, Cosmetic Surgery will be covered when it is due to:
 - a) reconstructive surgery incidental to, or follows surgery resulting from, trauma, infection or other diseases of the involved part; or
 - b) congenital disease or anomaly that has resulted in a functional defect;
- 7) a Person being legally intoxicated as defined by the law of the jurisdiction in which the incident occurs;
- 8) any event that occurs while a Person is incarcerated in a penal or correctional institution;
- 9) participation in any self asphyxiation method;
- 10) Surgery that is not Medically Necessary to treat a Sickness or Injury;
- 11) traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes;
- 12) engaging in any illegal or fraudulent occupation, work, or employment; or
- 13) any Injury or Sickness due to employment, and for which benefits are payable by any type of Workers' or Workmen's Compensation Law or any similar act or law.

SECTION 9 - EXCLUSIONS

PRE-EXISTING CONDITION EXCLUSION:

Benefits will not be paid if the Person's Disability begins in the first 12 months following the Person's Individual Effective Date of Insurance; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Person's Individual Effective Date of Insurance.

SECTION 9 - EXCLUSIONS

PRE-EXISTING CONDITION EXCLUSION ON AN INCREASED MAXIMUM WEEKLY BENEFIT: This provision applies to an increase in the Maximum Weekly Benefit that occurs after the Policyholder's Effective Date.

The policy will not cover the amount of the increase in the Maximum Weekly Benefit if the Person's Disability begins in the first 12 months following the effective date of the increase in coverage; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to his effective date of increase in amount of insurance.

PRE-EXISTING CONDITION EXCLUSION FOR A CHANGE IN OPTIONS: This provision applies when a Person changes Options resulting in an increase in coverage after the Policyholder's Effective Date.

The policy will not cover the Person under the new Option if the Person's Disability begins in the first 12 months following the Effective Date of Change in Options; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Effective Date of Change in Options.

A Person will receive benefits based on the Option he was previously insured under if eligible for such benefits according to the provisions applicable to that Option.

SECTION 14 - PORTABILITY PRIVILEGE

If a Person's insurance under the policy terminates for any reason other than stated below, the Person is entitled to continue his coverage for 12 months without submission of Evidence of Insurability. To be eligible for this Privilege, the Person must have been insured under the policy for at least 12 consecutive months just before insurance under the policy terminated.

This Portability Privilege provides the same coverage that the Person had immediately prior to the date of his termination. Any benefits payable are governed by the policy according to the provisions and benefits elected by the Policyholder and stated in the Schedule of Benefits. However, the Maximum Benefit Duration will be the lesser of:

- 1) 2 years; or
- 2) the Maximum Benefit Duration in effect immediately prior to the date of his termination.

This Portability Privilege is subject to the following:

- 1) application for Portability must be made via a method approved by AUL within 31 calendar days after termination of insurance under the policy;
- 2) payment of the initial correct amount of premium;
- 3) the premium is based on the Person's age and the premium rate in effect on the date of application for Portability; and
- 4) the effective date for the Person under the Portability Privilege is the date immediately following the date of his termination.

The Portability Privilege is not available to any Person:

- 1) whose insurance under the policy terminates for any of the following reasons:
 - a) the Person enters a class of Employees that are not eligible for coverage under the policy;
 - b) the Person retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career); or
 - c) the Person failed to pay any required premium;
- 2) who is or becomes insured for any other group long or short term disability policy which provides coverage similar to the type of coverage provided by the policy within 31 days after termination under the policy;
- 3) who is Disabled under the terms of the policy; or
- 4) who is on leave of absence.

Insurance under the Portability Privilege will terminate on the earliest of the following dates:

- 1) the last day for which any required premium has been made;
- 2) the date the Person requests termination, but not prior to the date of the request;
- 3) the last day of a Coverage Month, provided that AUL has given at least 31 days prior written notice to the Person;
- 4) the date the Person retires;
- 5) the date the policy terminates;
- 6) the date the Person enters active military service for any country, except for temporary duty of 30 days or less;
- 7) the date that coverage begins under any other group long or short term disability policy that provides coverage similar to coverage provided by the policy;
- 8) the date following 12 months of coverage; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for more than 6 months in any 12 month period.

SECTION 16A - VOCATIONAL REHABILITATION PROGRAM

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by AUL, prepares in accordance with this Vocational Rehabilitation Program section.

VOCATIONAL REHABILITATION PROGRAM: AUL's Vocational Rehabilitation Program is designed to assist a Person in returning to work. A Person's claim is reviewed and medical and vocational information is analyzed to determine if rehabilitation services might assist in this process.

AUL's Rehabilitation Program specialists, who coordinate with a Person's Physician and other specialists, complete an initial review. After this review, AUL may elect to offer and pay for a reasonable and necessary Vocational Rehabilitation Program. A Person must receive written approval from AUL, and a Vocational Rehabilitation Plan must be developed for the Person, before he is eligible for services under this provision. AUL will not reimburse unapproved or unnecessary rehabilitation expenses.

AUL's Vocational Rehabilitation Program may include coordination with other parties to:

- 1) assist in a Person's return to work;
- 2) evaluate adaptive equipment to allow a Person to work;
- 3) provide child care assistance during a Person's participation in a rehabilitation program;
- 4) provide vocational evaluation;
- 5) provide job placement services;
- 6) provide resume preparation;
- 7) provide job-seeking skills training;
- 8) provide retraining for a new occupation;
- 9) provide alternative treatment plans such as recommendations for:
 - a) support groups;
 - b) physical therapy;
 - c) occupational therapy;
 - d) speech therapy;
 - e) exercise programs;
 - f) mental health programs; or
 - g) other medical rehabilitation programs.

SECTION 17 - WORKPLACE MODIFICATION BENEFIT

WORKPLACE MODIFICATION means reasonable and necessary changes to a Person's work environment or to the way a Person's job is performed that enables the Person to return to full or part-time work for the Policyholder.

WORKPLACE MODIFICATION BENEFIT: AUL may pay the expense for any reasonable and necessary modification to a Person's workplace to accommodate the Person's Disability and enable him to return to Active Work for the Policyholder. The amount AUL may pay will not exceed the lesser of:

- 1) 2 times the Person's last Weekly Benefit payment; or
- 2) \$2,000.

To qualify for this Benefit:

- 1) a Person must be receiving a Weekly Benefit under the policy;
- 2) the Policyholder must agree to make reasonable and necessary modifications to the workplace that reasonably accommodates and enables a Person's return to full or part-time employment with the Policyholder; and
- 3) all proposed modifications and costs must be approved by AUL in advance and in writing prior to making any modification.

AUL may evaluate the appropriateness of a proposed modification.

AUL reserves the right, at its expense, to have a Person examined and evaluated by a Physician or other health care professional and a vocational expert or rehabilitation specialist of its choice, as frequently as it deems necessary.

If the Policyholder incurs reasonable and necessary costs for AUL approved modifications, the Policyholder will be reimbursed after:

- 1) proposed modifications made on the Person's behalf are completed;
- 2) written proof of incurred expenses for all modifications have been provided to and approved by AUL; and
- 3) the Person has returned to full or part-time employment with the Policyholder.

This Benefit will not be payable if:

- 1) expenses were not incurred in making the actual modification;
- 2) AUL did not provide written approval for the modification or its cost prior to the expense;
- 3) the Person becomes self-employed or returns to work for an employer other than the Policyholder;
- 4) the Person or Policyholder is able to apply or receives reimbursement for any costs under any other governmental program, grant, insurance policy, law or settlement; or
- 5) the Person ceases to be Disabled before or during the Workplace Modification.

This benefit is available on a one-time basis, per Person.

**SUMMARY OF THE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
AND
NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS**

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the association.

Coverage

Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

Persons holding such policies or contracts are not protected by this association if:

1. they are not residents of the State of Pennsylvania, except under very specific circumstances;
2. the insurer was not authorized to do business in Pennsylvania at the time the policy or contract was issued;
3. their policy was issued by a nonprofit hospital or health service corporation (e.g. a Blue Cross or Blue Shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

1. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
2. any policy of reinsurance (unless an assumption certificate was issued);
3. plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
4. interest rate yields that exceed an average rate;
5. dividends;
6. experience rating credits;
7. credits given in connection with the administration of a policy or contract;
8. annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
9. policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
10. sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
11. unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
12. financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
13. any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits on Amount of Coverage

The act also limits the amount the association is obligated to pay out; the association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall \$300,000 limit, the association will pay up to \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender or withdrawal values. For annuities, the association will pay up to \$300,000 in annuity benefits, or \$100,000 in net cash surrender or withdrawal benefits. For health insurance, the association will pay up to \$100,000, including any net cash surrender or withdrawal benefits.



**AMERICAN UNITED LIFE INSURANCE COMPANY®
INDIANAPOLIS, INDIANA 46206-0368**

Certifies that it has issued and delivered a policy to:

Insight Pennsylvania Cyber Charter School
(Hereinafter called the Policyholder)

Policy Number: G 00618131-0000-000
Class: 001

Change Effective Date: Does Not Apply

This certificate replaces any and all certificates previously issued to the insured Person under the policy indicated above.

American United Life Insurance Company® (AUL) certifies that the Person whose enrollment form is on file with the Policyholder or AUL as being eligible for insurance and for whom the required premium has been paid, is insured under the above numbered policy for group insurance benefits as designated in the Schedule of Benefits. Benefits as described in this certificate are subject to change.

This certificate describes the coverage provided in the policy. The policy determines all rights and benefits in this certificate and may be amended, canceled or discontinued at any time by agreement between AUL and the Policyholder without notice to the Person.

The policy may be examined at the main office of AUL during regular office hours.

Thomas M. Zurek
Secretary

J. Scott Davison
Chairman, President and Chief Executive Officer

**CERTIFICATE OF INSURANCE
GROUP WORKSITE DISABILITY INSURANCE - SHORT TERM**

TABLE OF CONTENTS

PROVISIONS	SECTION
Schedule of Benefits	1
Definitions	2
Eligibility, Enrollment and Individual Effective Date of Insurance	3
Changes in Insurance	4
Terminations	5
Individual Reinstatement	5A
Continuation of Personal Insurance under FMLA	5B
Continuation of Personal Insurance During a Leave of Absence and Temporary Layoff	5C
Continuation of Personal Insurance During a Leave of Absence for Active Military Service	5D
Premium Payment	6
General Policy Provisions	7
Claim Procedures	7A
Insuring Provisions	8
Exclusions	9
Portability Privilege	14
Vocational Rehabilitation Program	16A
Workplace Modification Benefit	17

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBLE CLASS	All Eligible Full-Time Employees Electing Option 2
CLASS NUMBER	001
OPTION NUMBER	02
REQUIREMENT FOR FULL-TIME EMPLOYEES	30.00 hours or more per week. See Section 3.
BASIC WEEKLY EARNINGS DESCRIPTION	For Sub-Chapter S-Corporation Shareholders: See Section 2. For Principals of a Partnership: See Section 2. For Sole Proprietors: See Section 2. For all other Employees: BWE Without Plan Contributions and No Commissions or Bonuses. See Section 2.
CHANGES IN INSURANCE	First of the Month. See Section 4.
CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)	This benefit is included for this class. See Section 5B.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF	This benefit is included for this class. See Section 5C.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE	This benefit is included for this class. See Section 5D.
COVERED WEEKLY EARNINGS	The amount of the Person's income in U.S. dollars, received from the Policyholder that is insured by the policy. This amount will be the LESSER of: 1) the Basic Weekly Earnings; or 2) the Maximum Weekly Benefit divided by the benefit percentage shown on the Schedule of Benefits.

SECTION 1 - SCHEDULE OF BENEFITS (continued)

Class 001-Option 02

ELIMINATION PERIOD	
INJURY	14 days. See Section 2.
SICKNESS	14 days. See Section 2.
GUARANTEED ISSUE AMOUNT	\$1,000. See Section 2.
LATE ENROLLEE	The Lesser of: 1) 60% of Pre-Disability Earnings; or 2) \$1,000. See Section 3.
INDIVIDUAL EFFECTIVE DATE	
INITIAL EMPLOYEES	Policyholder's Effective Date if the Employee has satisfied his Waiting Period on or before said date, otherwise the first day of the Coverage Month following the Initial Enrollment Period. See Section 3.
NEW EMPLOYEES	First day of the Coverage Month following the Initial Enrollment Period. See Section 3.
INDIVIDUAL REINSTATEMENT	This provision is included for this class. Application must be made within 30 days from termination date. Effective first day of the Coverage Month. See Section 5A.
INDIVIDUAL TERMINATIONS	Immediate. See Section 5.
INITIAL ENROLLMENT PERIOD	
INITIAL EMPLOYEES	Between 11/15/2018 and 12/31/2018.
NEW EMPLOYEES	31 days following the Employee's Eligibility Date. See Section 3.
MAXIMUM BENEFIT DURATION	26 Weeks. See Section 2.
MAXIMUM WEEKLY BENEFIT	\$1,000. See Section 2.
MINIMUM WEEKLY BENEFIT	\$25. See Section 8.
OCCUPATIONAL INJURY OR SICKNESS	Non-Occupational. See Section 2.
ORGAN DONOR TRANSPLANT BENEFIT	This benefit is included for this class. See Section 8.
OTHER INCOME BENEFITS	Applies to this class. See Section 2.
PARTIAL DISABILITY	This benefit is included for this class. See Section 8.
POLICY MONTH	A period that begins on the first day of the month and ends on the last day of the month. Each succeeding Policy Month runs for a similar period thereafter.
PORTABILITY PRIVILEGE	This benefit is included for this class. See Section 14.

SECTION 1 - SCHEDULE OF BENEFITS (continued)

Class 001-Option 02

PRE-EXISTING CONDITION DURATION	3/12. See Section 9.
RECURRENT DISABILITY	30 days. See Section 8.
RESIDUAL BENEFIT	This benefit is included for this class. See Section 8.
SCHEDULED ENROLLMENT PERIOD	Period of time chosen by the Policyholder and approved by AUL. See Section 3.
SOCIAL SECURITY INTEGRATION	Direct Full Family. See Section 8.
TOTAL DISABILITY DEFINITION	Regular Job. See Section 2.
VOCATIONAL REHABILITATION PROGRAM (VOLUNTARY)	This benefit is included for this class. See Section 16A.
WAITING PERIOD	0 days. See Section 2.
WAIVER OF PREMIUM	This benefit is included for this class. See Section 6.
WEEKLY BENEFIT	60% of Basic Weekly Earnings not to exceed Maximum Weekly Benefit of \$1,000. The Weekly Benefit will be reduced by Other Income Benefits. See Section 8.
WORKPLACE MODIFICATION BENEFIT	This benefit is included for this class. See Section 17.

SECTION 2 - DEFINITIONS

ACTIVE WORK and ACTIVELY AT WORK means the use of time and energy in the services of the Policyholder at the regular place of employment, or an alternative worksite as approved by the Policyholder and AUL, by a Person who is physically and mentally capable of performing each of the Material and Substantial duties of his Regular Job and who is a Full-Time Employee. If the alternative worksite is located outside of the United States or Canada, the Person will be considered to be Actively at Work unless the Person is outside of the United States or Canada for more than 6 months in any 12 month period. Active Work does not include periods of time when an Employee is not Actively at Work following an Injury, accidental bodily injury, Sickness, strike, lock-out, or Temporary Layoff.

This includes time off for vacation, jury duty, paid holidays, and funeral leave, where the Person could have been Actively at Work on that day.

ANY OCCUPATION means a Person's occupation for which he receives remuneration.

SECTION 2 - DEFINITIONS

For sub-chapter S corporation shareholders: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars before taxes, received from the Policyholder. Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability and is further based on:

- 1) the weekly average of the Person's gross income on his last reported Federal IRS W-2 Form shown as wages, tips, and other compensation. Earnings include pre-tax contributions to an employer-sponsored defined contribution plan and a cafeteria plan, if any. If the Person has not worked long enough to receive a Federal IRS W-2 Form from the Policyholder, gross weekly income will be the weekly average of the last amount of gross income reported to AUL in writing by the Policyholder for which premiums were paid and the coverage amount was approved in writing by AUL; and
- 2) shareholder earnings reported as ordinary income (loss) for trade or business activities on the Sub S corporation's Federal IRS Tax Form Schedule K-1 1120S, or similar form acceptable to AUL, averaged for the LESSER of:
 - a) the most recent 3 years; or
 - b) the period that the Person has been a shareholder.

The last reported earnings should be adjusted annually upon completion of the tax form, a copy of which should be submitted to AUL. AUL will use the earnings amount last reported in writing, for which premiums were paid, and the coverage amount was approved by AUL in writing before the Person's Date of Disability.

For principals of a partnership: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars before taxes, received from the Policyholder, not to exceed a maximum workweek of 40 hours including Partnership Earnings. Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings do not include income received from commissions, bonuses, overtime, or expense accounts.

Partnership Earnings will be the weekly average of the amount shown as "net earnings (loss) from self-employment" from Schedule K-1 of the partnership federal income tax return for the LESSER of:

- 1) the 3 most recent years; or
- 2) the total number of months the Person was a partner, if the Person was not a partner for the entire 3 years.

The reported earnings should be adjusted annually upon completion of the tax form, a copy of which should be submitted to AUL. AUL will use the earnings amount last reported and approved in writing by AUL before the Person's Date of Disability.

SECTION 2 - DEFINITIONS

For sole proprietors: BASIC WEEKLY EARNINGS means the Person's annual net profit in U.S. dollars averaged for the LESSER of:

- 1) the 3 most recent years; or
- 2) the period that the Person has been a sole proprietor.

Gross income is based on the amount as last reported to AUL in writing by the Policyholder and approved in writing by AUL, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings are based upon the number taken from Schedule C of Federal IRS Form 1040 for the weekly average of 3 business years immediately prior to reporting. The reported earnings should be adjusted annually following completion of the appropriate tax form, a copy of which should be submitted to AUL. AUL will use the net profit amount last reported in writing, for which premiums were paid and the coverage amount was approved in writing by AUL before the Person's Date of Disability.

SECTION 2 - DEFINITIONS

For all other Employees: BASIC WEEKLY EARNINGS means the Person's gross weekly income in U.S. dollars, before taxes, received from the Policyholder not to exceed a maximum workweek of 40 hours. Gross weekly income does not include pre-tax contributions to an employer sponsored defined contribution plan and a cafeteria plan, if any. These earnings are based on the amount as last reported to AUL in writing by the Policyholder, for which premiums were paid and the coverage amount was approved in writing by AUL before the Date of Disability. Earnings do not include income received from commissions, bonuses, overtime, or expense accounts.

If the Person is paid his annual gross income in less than 52 weeks, the Basic Weekly Earnings shall equal 1/52 of the annual gross income.

SECTION 2 - DEFINITIONS

CHILD(REN) means a minor related by blood, marriage or court order that can be claimed as a dependent for federal income tax purposes, such as:

- 1) natural born child(ren) of the Person;
- 2) legally adopted child(ren) of the Person from the time of placement in the Person's home and the filing of documents with the court to adopt;
- 3) stepchild(ren) who lives with the Person; and
- 4) child(ren) for whom the Person has legal guardianship.

COMPENSATORY TIME means time off with pay in lieu of overtime pay for regularly scheduled or irregular or occasional overtime work.

CONSUMER PRICE INDEX (CPI) means the statistical measure of the average change in prices figured by the United States Dept. of Labor, Bureau of Labor Statistics. The percent change in the Consumer Price Index for all Urban Consumers (CPI-U); U.S. City Average for All Items, for the prior calendar year will be used in calculations. If the CPI is discontinued or if its method of computation is significantly changed, AUL may use another comparable index.

COSMETIC SURGERY means surgery that is performed to change the texture, shape or structure of any part of the human body for the purpose of creating a different visual appearance.

COVERAGE MONTH means that period of time beginning on the Person's Individual Effective Date, and continuing from the first day and ending on the last day of each succeeding Policy Month.

CURRENT WEEKLY INCOME means the income a Person receives while Disabled, plus the income the Person could receive if he were working to his Maximum Capacity. Current Weekly Income does not include income from Salary Continuance.

If a Person is employed in a second job, at the same time he is Actively at Work as a Full-Time Employee for the Policyholder, and becomes Disabled under the policy, the following will apply during the Elimination Period and while receiving Disability benefits under the policy:

- 1) any income received from the second job will be considered Current Weekly Income only to the extent that it exceeds the average weekly income received from that job during the 6 month period immediately prior to becoming Disabled; and
- 2) if the Person has worked for the second employer less than 6 months, the income will be averaged for the total number of months he was employed.

If a Person receives Current Weekly Income in a Lump Sum, the Lump Sum Payment provision will apply.

SECTION 2 - DEFINITIONS

DATE OF DISABILITY means the first date the Person is Disabled.

DATE OF HIRE means the first day the Employee is Actively at Work in an eligible class for the Policyholder.

DISABILITY and DISABLED mean both Total Disability and Totally Disabled and Partial Disability and Partially Disabled.

DUE DATE means the first day of the Policy Month for which the premium is payable.

ELIGIBILITY DATE means the date that an Employee in an eligible class has satisfied his Waiting Period and AUL determines he is eligible for Personal Insurance under the policy.

ELIGIBLE SURVIVOR means:

- 1) the Person's legal Spouse; or
- 2) the Person's unmarried Child(ren) under the age of 26, if the Child(ren) can be claimed as a dependent on the Person's federal income tax return.

ELIMINATION PERIOD means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is set forth on the Schedule of Benefits and begins on the first day of Disability.

SECTION 2 - DEFINITIONS

EMPLOYEE means any individual who is a full-time employee (including owners, proprietors, partners, members or corporate officers) of the Policyholder:

- 1) whose employment with the Policyholder constitutes his principal occupation;
- 2) who works at that occupation a minimum number of hours as stated by the Policyholder in the Application;
- 3) who is working at the Policyholder's regular place of business which may include an alternative worksite if approved by the Policyholder and AUL;
- 4) who is not a part-time, temporary or seasonal Employee; and
- 5) who is authorized to work in the United States under applicable state and federal laws; or
- 6) if approved by AUL:
 - a) who legally works and resides in Canada;
 - b) who legally works in the United States and resides in Canada; or
 - c) who legally works in Canada and resides in the United States.

EMPLOYER means the entity or organization for which the Person performs services and which has the right to control what will be done. The Employer is the entity or organization for which the Person performs his occupation, and is required to withhold and pay income, Social Security, and Medicare taxes on wages.

EMPLOYER'S RETIREMENT PLAN means any defined benefit or defined contribution plan that provides retirement benefits to Employees and that is not funded wholly by Employee contributions. It includes any retirement plan that:

- 1) is part of any federal, state, county, municipal or association retirement system; and
- 2) that a Person is eligible for as a result of his employment with the Policyholder.

It does not include:

- 1) profit sharing plans;
- 2) thrift or savings plans;
- 3) Individual Retirement Accounts (IRAs) or Roth IRAs funded wholly by a Person's contributions;
- 4) Tax Sheltered Annuities (TSA);
- 5) Stock Ownership Plans (ESOP);
- 6) nonqualified deferred compensation plans, including 457 plans;
- 7) Keogh, 401(k) or 403(b) plans; or
- 8) Veteran Administration Benefits except benefits that are a result of the same Disability for which a Weekly Benefit is payable under the policy.

EVIDENCE OF INSURABILITY means a statement or proof of an Employee's medical history upon which eligibility for insurance will be determined by AUL.

SECTION 2 - DEFINITIONS

FAMILY SOCIAL SECURITY BENEFITS means benefits that a Person, his Spouse or Child(ren) are entitled to receive as a result of the Person's eligibility for disability insurance benefits or old age insurance benefits through the Federal Social Security Administration.

FAMILY STATUS CHANGE means an increase or decrease in coverage resulting from specific events occurring in a Person's life.

FRANCHISE COVERAGE means disability insurance coverage which allows Employees to be insured as part of their relationship with the Policyholder but such coverage is not part of an employee welfare benefit plan and the Employees are insured under individual policies.

GROSS WEEKLY BENEFIT means a Person's Weekly Benefit before any reduction for Other Income Benefits.

GUARANTEED ISSUE AMOUNT means the amount of coverage that does not require Evidence of Insurability. This amount is shown on the Schedule of Benefits page.

INDEXED PRE-DISABILITY EARNINGS means the Person's Pre-Disability Earnings increased annually by the Consumer Price Index, up to a maximum increase of 10%. The increase will be effective on the July 1st following the first 12 consecutive calendar months of receiving Disability benefits and on each subsequent July 1st.

INDIVIDUAL REINSTATEMENT means that Personal Insurance that has been terminated due to cessation of Active Work may be reinstated in accordance with Section 5A.

INJURY means a sudden, unforeseen and unexpected event that occurs independently of all other causes and causes physical harm to the Person. This includes all other conditions related to the same Injury.

MALE PRONOUN whenever used includes the female.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- 1) are normally required for the performance of an occupation; and
- 2) cannot be reasonably omitted or modified.

SECTION 2 - DEFINITIONS

MAXIMUM BENEFIT DURATION means the maximum amount of time that benefits will be payable for Disability. This amount of time is stated on the Schedule of Benefits.

MAXIMUM CAPACITY means, based on the Person's restrictions and limitations, the greatest extent of work the Person is able to do in his Regular Job.

MAXIMUM WEEKLY BENEFIT means the maximum amount of benefit payable to a Person on a weekly basis as stated on the Schedule of Benefits.

MEDICALLY NECESSARY means health care services that a Physician, exercising prudent clinical judgment, would provide to a Person for the purpose of evaluating, diagnosing or treating a Sickness or Injury, or its symptoms, and that are:

- 1) in accordance with the generally accepted standards of medical practice;
- 2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Person's Sickness or Injury; and
- 3) not primarily for the convenience of the Person or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Person's Sickness or Injury.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the *Diagnostic and Statistical Manual of Mental Health Disorders (DSM)*, published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the *DSM* is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability.

SECTION 2 - DEFINITIONS

OPTION means the benefits and provisions chosen on the Application by the Policyholder.

OPTION YEAR means a one-year period beginning on the Policyholder's Anniversary Date or on each subsequent anniversary of the Policyholder's Anniversary Date.

OTHER INCOME BENEFITS means those benefits listed below that the Person, his Spouse or Child(ren) are entitled to receive. It includes any benefit for which they are eligible, or that is paid to them or a Third Party on their behalf, including:

- 1) disability income benefits, including any damages or settlements made in place of such benefits (whether or not liability is admitted) under:
 - a) any automobile liability insurance or “no fault” motor vehicle plan, whichever is applicable;
 - b) a Third Party (after subtracting attorney’s fees) by judgment, settlement or otherwise not to exceed 50% of the net settlement;
 - c) state compulsory benefit law, including any state disability income benefit law or similar law;
 - d) disability benefits from the Veteran’s Administration, or any other foreign or domestic governmental agency, that begins *after* a Person becomes Disabled. This includes the amount of any increase in a benefit that a Person was receiving prior to becoming Disabled if the increase is attributed to the same disability for which the Person is currently receiving a Weekly Benefit under the policy; and
 - e) any other similar act or law;
- 2) any disability income benefit for which the Person is eligible under any other employee welfare benefit plan, or arrangement of coverage, whether insured or not, as a result of the Person’s employment with the Policyholder;
- 3) retirement and/or disability income benefits paid under an Employer’s Retirement Plan except for amounts attributable to a Person’s contributions;
- 4) any disability income or retirement benefit that has been received or is eligible to be received from:
 - a) the Social Security Administration or any similar law, plan or act, including the initial enactment and all amendments;
 - b) the Canada Pension Plan;
 - c) the Quebec Pension Plan;
 - d) the Railroad Retirement Act; or
 - e) any other state, provincial or local government act or law or any other similar act or law provided in any jurisdiction;
- 5) any amounts received from partnership or proprietorship draws or similar draws; and
- 6) any Current Weekly Income.

SECTION 2 - DEFINITIONS

The following items are NOT considered Other Income Benefits and will not be deducted from the Gross Weekly Benefit payable to the Person:

- 1) profit sharing plans;
- 2) thrift or savings plans;
- 3) Individual Retirement Accounts (IRA) or Roth IRAs funded wholly by a Person's contributions;
- 4) Tax Sheltered Annuities (TSA);
- 5) Stock Ownership Plans (ESOP);
- 6) nonqualified deferred compensation plans, including 457 plans;
- 7) Keogh, 401(k) or 403(b) plans;
- 8) Veteran Administration Benefits except those benefits that are a result of the same Disability for which a Weekly Benefit is payable under the policy;
- 9) credit disability insurance;
- 10) pension plans for partners;
- 11) individual disability policies paid for by the Person and not sponsored by the Policyholder;
- 12) Social Security Widow's benefits paid under the deceased Spouse's earnings record;
- 13) Social Security retirement income received by the Person if his disability begins after age 62 and he was already receiving Social Security retirement income payments;
- 14) Retirement plans from other employers; and
- 15) Salary Continuance Plans.

SECTION 2 - DEFINITIONS

PARTIAL DISABILITY and PARTIALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the Material and Substantial Duties of his Regular Job as a Full-Time Employee, but:

- 1) is performing at least one of the Material and Substantial Duties of his Regular Job, or another occupation, on a part or full-time basis;
- 2) his Current Weekly Income is less than 80% of his Indexed Pre-Disability Earnings due to the same Injury or Sickness that caused his Disability; and
- 3) he is under the Regular Attendance of a Physician for that Injury and Sickness.

Loss of occupational license for any reason does not in itself constitute Partial Disability.

PERSON means an Employee who has met the requirements of the Eligibility, Enrollment and Individual Effective Date of Insurance Sections of the policy.

PERSONAL INSURANCE means the insurance provided under the policy for an insured Person.

PHYSICIAN means a qualified, state licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, practicing within the scope of his license and applicable law. Physician does not include a Physician employed by the Policyholder, a Person or anyone related to a Person by blood, marriage, civil union, or domestic partnership.

SECTION 2 - DEFINITIONS

POLICYHOLDER means any sole proprietorship, partnership, member, corporation, limited liability company, limited liability partnership, firm, school district, individual school, union, association, organization or other instrumentality of a state or political subdivision thereof, that has been approved by AUL and to whom the policy is issued. An entity that is subsidiary to or affiliated with the Policyholder, as defined below is eligible for coverage under the policy if it is shown on the Application or later added by amendment to the policy.

A subsidiary may be included in this definition when the Policyholder owns more than 50% of the voting stock of the subsidiary corporation.

An affiliate may be included in this definition when the entity is under common control with the Policyholder through 51% or more ownership and control.

The Policyholder is liable for all premiums due for subsidiaries and affiliates during any period of time a subsidiary and/or affiliate is insured under the policy. Any notice given to the Policyholder by AUL shall be considered notice given to the subsidiary and/or affiliate.

POLICYHOLDER'S EFFECTIVE DATE means the date that coverage is actually effective for the Policyholder under the policy, as determined by AUL.

POLICYHOLDER'S ANNIVERSARY DATE means January 1st of each year.

PRE-DISABILITY EARNINGS means the Person's Basic Weekly Earnings in effect immediately prior to his Date of Disability, as last reported to AUL in writing by the Policyholder.

PRE-EXISTING CONDITION means any condition for which a Person has done any of the following at any time during the 3 months immediately prior to the Person's Individual Effective Date of Insurance, whether or not that condition was diagnosed at all or was misdiagnosed during that period of time:

- 1) received medical treatment or consultation;
- 2) taken or were prescribed drugs or medicine; or
- 3) received care or services, including diagnostic measures.

SECTION 2 - DEFINITIONS

PRIMARY SOCIAL SECURITY BENEFITS means benefits that the Person is entitled to receive for himself as a result of his eligibility for benefits through the Social Security Administration.

PRIOR PLAN means the Policyholder's plan of long or short term disability insurance, which terminated on the day immediately before the Policyholder's Effective Date of coverage under the policy.

REGULAR ATTENDANCE means that a Person:

- 1) personally visits a Physician as medically required according to standard medical practice, to effectively manage and treat the Person's Disability;
- 2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in his return to work; and
- 3) is receiving care by a Physician whose specialty or clinical experience is appropriate for the Disability.

SALARY CONTINUANCE means vacation pay, sick leave pay and/or paid time off pay, holiday pay and a documented formal salary continuation plan for Sickness or Injury received by a Person after his Date of Disability.

SICKNESS means illness, bodily disorder or disease, Mental Illness, normal pregnancy and Complications of Pregnancy. Complications of Pregnancy is defined as a concurrent disease or abnormal conditions significantly affecting the usual medical management of pregnancy.

SOCIAL SECURITY means the United States Social Security Act or any similar law, plan or act including the initial enactment and all amendments.

SPOUSE means:

- 1) an individual to whom the Person is legally married; or
- 2) the Person's civil union partner or domestic partner, as defined by applicable law.

Spouse does not include an individual from whom the Person is divorced or from whom the Person has dissolved a civil union or a domestic partnership.

SECTION 2 - DEFINITIONS

TERMINAL ILLNESS means a diagnosed illness that, according to generally accepted medical standards, is expected to result in death within 12 months.

THIRD PARTY means an individual, entity or an insurance company other than AUL.

TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness:

- 1) a Person cannot perform the Material and Substantial Duties of his Regular Job;
- 2) a Person is not working in any occupation; and
- 3) a Person is under the Regular Attendance of a Physician for that Injury or Sickness.

Loss of occupational license for any reason does not in itself constitute Total Disability.

WAITING PERIOD means the period of days, starting on the Date of Hire, that an Employee must be continuously Actively at Work while in an eligible class. The Waiting Period is stated in the Schedule of Benefits.

WEEKLY BENEFIT means the amount payable weekly by AUL to the Disabled Person. It is the Gross Weekly Benefits, reduced by Other Income Benefits.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

INITIAL EMPLOYEE means an Employee who is employed by the Policyholder before the Policyholder's Effective Date.

NEW EMPLOYEE means an Employee who is employed by the Policyholder on or after the Policyholder's Effective Date.

LATE ENROLLEE: A Late Enrollee is an Initial or New Employee who is Actively at Work, but does not request coverage during his Initial Enrollment Period. Enrollment after the Initial Enrollment Period can only be done during a Scheduled Enrollment Period and will not require satisfactory Evidence of Insurability.

ELIGIBILITY DATE: An Employee who is in an eligible class as stated in the Schedule of Benefits and has satisfied his Waiting Period, becomes eligible for Personal Insurance under the policy on:

- 1) *Initial Employee*: the later of:
 - a) the Policyholder's original Effective Date of coverage under the policy; or
 - b) the day immediately following completion of the Waiting Period.
- 2) *New Employee*: the first day of the Coverage Month immediately following completion of the Waiting Period.
- 3) *Late Enrollee*: the Policyholder's Anniversary Date following the next Scheduled Enrollment Period.

ENROLLMENT: To be considered for coverage, an eligible Employee must apply correctly and truthfully for Personal Insurance under the policy. Eligible Employees applying for Personal Insurance must complete and sign a request for coverage via an enrollment method approved by AUL within 31 days of their Eligibility Date and pay the required premiums before coverage will become effective. This form will be given to and maintained by the Policyholder. Coverage may only be requested as follows:

- 1) INITIAL ENROLLMENT PERIOD: The Initial Enrollment Period is the time during which an eligible Employee who is Actively at Work may first enroll for coverage following completion of the Waiting Period without providing Evidence of Insurability. An eligible Employee may waive coverage or request coverage under any Option offered by the Policyholder for his class. The Initial Enrollment Period includes the following periods, during which an Employee may make his initial application for coverage under the policy:
 - a) *Initial Employee*: the Initial Enrollment Period is the period of time agreed to by AUL and the Policyholder and is stated on the Schedule of Benefits; or
 - b) *New Employee*: the Initial Enrollment Period is the period that begins on the Eligibility Date and continues through the number of days as stated in the Schedule of Benefits; or
 - c) *Initial or New Employee not Actively at Work during his Initial Enrollment Period*: an Initial or New Employee not Actively at Work during his Initial Enrollment Period may enroll, without Evidence of Insurability, within 31 days from the date he returns to Active Work if:
 - i) he is in an eligible class as stated in the Schedule of Benefits; and
 - ii) his Waiting Period was completed prior to his cessation of Active Work.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

- 2) SCHEDULED ENROLLMENT PERIOD: This is a recurrent period of time starting after the Policyholder's original Effective Date, chosen by the Policyholder and approved by AUL, during which:
- a) an eligible Late Enrollee may apply for coverage under the policy via an enrollment method approved by AUL; or
 - b) an eligible Late Enrollee may apply, via an enrollment method approved by AUL, for a Weekly Benefit amount in excess of the Guaranteed Issue Amount for Late Enrollees as stated in the Schedule of Benefits with satisfactory Evidence of Insurability. See Section 4.

The Scheduled Enrollment Period is chosen by the Policyholder and must be approved by AUL.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

INDIVIDUAL EFFECTIVE DATE OF INSURANCE

Initial Employees:

- 1) The Individual Effective Date of Insurance for an eligible Initial Employee who has satisfied the Waiting Period prior to the Policyholder's original Effective Date is the Policyholder's original Effective Date under the policy as long as the Initial Employee:
 - a) requested coverage during the Initial Enrollment Period; and
 - b) is Actively at Work for the Policyholder on that date.
- 2) The Individual Effective Date of Insurance for an eligible Initial Employee who has not satisfied the Waiting Period prior to the Policyholder's original Effective Date is stated on the Schedule of Benefits and applies as long as the Initial Employee:
 - a) requested coverage during the Initial Enrollment Period; and
 - b) is Actively at Work for the Policyholder on that date.

New Employees: The Individual Effective Date of Insurance for an eligible New Employee is the date of the request if that date is the first day of a Coverage Month; otherwise it is the first day of the next Coverage Month as long as the New Employee:

- 1) requested coverage during the Initial Enrollment Period;
- 2) has completed the Waiting Period for New Employees; and
- 3) is Actively at Work on the Individual Effective Date of Insurance.

Initial or New Employee not Actively at Work during his Initial Enrollment Period: The date an Initial or New Employee returns to full-time Active Work will be his Individual Effective Date of Insurance, if he was enrolled during an Initial Enrollment Period, has completed the Waiting Period for Initial Employees, but was not Actively at Work on the date Personal Insurance would otherwise have become effective.

If enrolling after returning to Active Work, the Individual Effective Date of Insurance for an Initial or New Employee not Actively at Work is the first day of the Coverage Month following the Initial Enrollment Period.

**SECTION 3 - ELIGIBILITY, ENROLLMENT and
INDIVIDUAL EFFECTIVE DATE OF INSURANCE**

Late Enrollee: The Individual Effective Date of Insurance for an eligible Late Enrollee is the Policyholder's Anniversary Date following the Scheduled Enrollment Period as long as the Late Enrollee:

- 1) requested coverage during the Scheduled Enrollment Period;
- 2) has completed the Waiting Period for New Employees; and
- 3) is Actively at Work on the Individual Effective Date of Insurance.

COVERAGE IN EXCESS OF GUARANTEED ISSUE AMOUNT: The Individual Effective Date of Insurance as previously explained applies to any portion of the Maximum Weekly Benefit that does not exceed the Guaranteed Issue Amount. However, any portion of the Maximum Weekly Benefit that exceeds the Guaranteed Issue Amount will require Evidence of Insurability, satisfactory and without expense to AUL. If the excess portion is approved, the Effective Date of Insurance for that portion will be named by AUL. If the excess portion is not approved by AUL, the Maximum Weekly Benefit will be an amount equal to the Guaranteed Issue Amount.

Evidence of Insurability: Documentation and records are required to be forwarded to AUL, at no cost to AUL, if the request for coverage is made:

- 1) after an Employee's Initial Period;
- 2) after a Person's requested termination date; or
- 3) for coverage in excess of the Guaranteed Issue Amount.

If satisfactory Evidence of Insurability is provided, and coverage is approved in writing by AUL, the Individual Effective Date of Insurance will be named by AUL.

SECTION 4 - CHANGES IN INSURANCE

EFFECTIVE DATE OF CHANGE (First of the Coverage Month & No AIB)

A change in coverage that does not increase the amount of coverage becomes effective on:

- 1) the first day of the Coverage Month following AUL's approval of the change, if the date is the first day of the Coverage Month; or
- 2) the first day of the next Coverage Month following AUL's approval of the change, if the date is after the first day of the Coverage Month.

Prior to a change in coverage that increases the amount of coverage, the Person must be Actively at Work and the required amount of premium must be paid.

A change increasing the amount of coverage is subject to:

- 1) satisfactory Evidence of Insurability, at no expense to AUL; and
- 2) AUL's written approval.

If the Person is not Actively at Work on the approved change date, any change in the amount of coverage takes effect on the date the Person returns to Active Work.

If the change is an increase in coverage, see Pre-Existing Condition Exclusions in Section 9.

SECTION 4 - CHANGES IN INSURANCE

CHANGING OPTION: After the Initial Enrollment Period, a Person may increase his coverage to another Option available to his class during a Scheduled Enrollment Period as agreed to by the Policyholder and approved by AUL. The request for a change in Option and agreement to pay the required premium must be made via a method approved by AUL, subject to the following:

- 1) an increase in coverage to the next higher Option available to a Person's class will require Evidence of Insurability;
- 2) requests to increase coverage to an Option other than the next higher Option will not be allowed with satisfactory Evidence of Insurability; and
- 3) if a Person fails to apply for an increase in coverage in a manner agreed to by the Policyholder and approved by AUL, he will continue to be covered under his current Option until the next Scheduled Enrollment Period.

If the Person is not Actively at Work on the Effective Date of Change, the Person becomes eligible for the change on the first day that the Person returns to Active Work.

The provision entitled Pre-Existing Condition Exclusion For A Change In Option, shown in Section 9 - Exclusions, will apply to a change in Option resulting in an increase in coverage.

DECREASING THE WEEKLY BENEFIT AMOUNT: A Person may decrease the amount of his coverage at any time. Any decrease in coverage will become effective the first day of the Coverage Month following the date of the request.

Any change in insurance, other than a decrease in the amount of coverage or an increase in coverage to the next higher Option as stated above, will require satisfactory Evidence of Insurability.

If the change is an increase in coverage, see Pre-Existing Condition Exclusions in Section 9.

SECTION 4 - CHANGES IN INSURANCE

FAMILY STATUS CHANGE

A Person may request an additional amount of coverage or a Late Enrollee may request coverage, without Evidence of Insurability, up to the Guaranteed Issue Amount as stated in the Schedule of Benefits if all the following conditions are met:

- 1) The Person or Late Enrollee experienced one of the following changes in family status:
 - a) legal marriage;
 - b) domestic partnership or civil union, as defined under applicable laws in the state of residence of the Person;
 - c) divorce or dissolution of a domestic partnership or civil union;
 - d) birth of a child;
 - e) adoption of a child or stepchild; or
 - f) permanent legal custody or guardianship of a child lasting more than 90 days;
- 2) AUL was notified within 31 days of the change in family status;
- 3) the Person or Late Enrollee was Actively at Work on the effective date of the change;
- 4) the amount of coverage after the increase is not greater than the Weekly Benefit amount stated in the Schedule of Benefits; and
- 5) the Person or Late Enrollee has not previously been declined.

This change will become effective the first day of the Coverage Month following the date of the request.

If coverage for a Person or Late Enrollee was previously declined due to unsatisfactory Evidence of Insurability, no Family Status Change will be approved until Evidence of Insurability satisfactory to AUL is received. If the Person's or Late Enrollee's Family Status Change request is approved, coverage will begin on the date identified in writing by AUL.

SECTION 5 - TERMINATIONS

INDIVIDUAL TERMINATIONS: A Person will cease to be insured on the EARLIEST of the following dates:

- 1) the date the policy terminates;
- 2) the date the Person is no longer in an eligible class;
- 3) the date the Person's class, as stated on the Schedule of Benefits, is no longer insured under the policy;
- 4) the last day of the period for which premiums were paid, if the premium is not paid when due;
- 5) the date the Person requests termination, but not prior to the date of the request;
- 6) the date employment terminates. However, insurance will be continued for a Person:
 - a) during the Elimination Period, if the Person is Disabled, as described in the policy;
 - b) during any period that premiums are being waived under the Waiver of Premium provision;
 - c) during any temporary Leave of Absence according to the appropriate Continuation of Personal Insurance benefit if premiums continue to be paid during the Leave of Absence, and the benefit was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL;
 - d) to the end of the Coverage Month following the month that a Person is temporarily laid off as long as premiums continue to be paid, if coverage during a temporary layoff was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL; and
- 7) the date the Person ceases Active Work. However, insurance will be continued for a Person:
 - a) during the Elimination Period, if the Person is Disabled, as described in the policy;
 - b) during any period that premiums are being waived under the Waiver of Premium provision;
 - c) during any temporary Leave of Absence according to the appropriate Continuation of Personal Insurance benefit if premiums continue to be paid during the Leave of Absence, and the benefit was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL; and
 - d) to the end of the Coverage Month following the month that a Person is temporarily laid off as long as premiums continue to be paid, if coverage during a temporary layoff was elected by the Policyholder, shown on the Schedule of Benefits and approved by AUL.

SECTION 5 - TERMINATIONS

TERMINATION OF THE POLICY: Insurance coverage under the policy will cease on the EARLIEST of the following dates:

- 1) the date the Policyholder no longer meets the definition of a Policyholder;
- 2) the date the Policyholder ceases active business operations or is placed in bankruptcy or receivership;
- 3) the date the Policyholder loses its entity by means of dissolution, merger, or otherwise;
- 4) the date ending the Policy Month for which the last premium payment is made for the Policyholder's insurance;
- 5) at the end of a Policy Month, provided AUL has given at least 31 days prior written notice to the Policyholder;
- 6) at the end of the Policy Month, if the Policyholder has given AUL at least 31 days prior written notice;
- 7) the date, as determined by AUL, that the Policyholder fails to promptly furnish any information which AUL may reasonably require; or
- 8) the date the Policyholder, without good and sufficient cause, fails to perform in good faith its duties pertaining to the policy.

If a Person's insurance is terminated due to the termination of the policy, the Person's rights under the policy are terminated on the date that the policy terminated.

Termination of the policy under any conditions will be without prejudice to any claim incurred prior to termination.

If the policy terminates, the Policyholder will be liable to AUL for all unpaid premiums for the period during which the coverage was in force.

SECTION 5 - TERMINATIONS

EXTENDED BENEFIT: If the Person is Disabled on the date insurance terminates, AUL will pay benefits for Disability:

- 1) after the Elimination Period has been met, if the Person is not already receiving a Weekly Benefit;
- 2) during the uninterrupted continuance of the same period of Disability; and
- 3) subject to the provisions and benefits of the policy.

Benefits will be extended to the EARLIEST of the following:

- 1) the date Current Weekly Income equals or exceeds 80% of the Indexed Pre-Disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration, shown on the Schedule of Benefits, is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide information to AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive weeks of benefits.

SECTION 5A - INDIVIDUAL REINSTATEMENT

INDIVIDUAL REINSTATEMENT: If Personal Insurance terminates under the policy due to cessation of Active Work for the Policyholder, it may be reinstated subject to the terms of this provision. Individual Reinstatement must be requested during the 31-day period immediately following return to Active Work for the Policyholder in accordance with the terms stated in this provision. Individual Reinstatement will be for the same coverage amount and eligible class that the Employee belonged to immediately prior to his termination. AUL may require Evidence of Insurability if reinstatement is requested for an amount or eligible class that differs from the coverage the Employee had with the Policyholder immediately prior to his cessation of Active Work. Reinstatement is subject to payment of required premiums and that the Policyholder is insured by AUL under the policy. In addition to the above requirements, the following also applies, as applicable:

- 1) If an Employee returns to Active Work within the period of consecutive calendar days as stated in the Schedule of Benefits under Individual Reinstatement from his individual termination date and requests Individual Reinstatement:
 - a) Personal Insurance will become effective the first day of the Coverage Month immediately following the date of request for Individual Reinstatement.
 - b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Employee under the policy immediately prior to cessation of Active Work.
 - c) *If the Schedule of Benefits states that the Employee must return to Active Work within 30 days of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period and of the Pre-Existing Condition exclusion or limitation period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the eligibility Waiting Period and the Pre-Existing Condition exclusion or limitation period.
 - d) *If the Schedule of Benefits states that the Employee can return to Active Work for a period greater than 30 days from the Employee's date of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The Employee will be considered a New Employee and subject to the terms of the policy, except as stated herein.
- 2) If an Employee returns to Active Work after more than the number of consecutive calendar days, shown in 1) above, after his Individual Termination date and requests Individual Reinstatement:
 - a) The Employee will be considered a New Employee and subject to the terms of the policy.
 - b) Eligibility for Personal Insurance, enrollment and his Individual Effective Date of Insurance will be determined as stated in the policy.
 - c) The Waiting Period and Pre-Existing Condition exclusion or limitation period will start anew. The Individual Reinstatement date will be used when applying the Pre-Existing Condition exclusion or limitation period.
- 3) If the Employee is insured under the policy's Portability Privilege and returns to Active Work with the Policyholder and requests Individual Reinstatement to the policy.
 - a) Personal Insurance will become effective the first day of the Coverage Month immediately following the date of request for Individual Reinstatement.
 - b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Employee under the policy immediately prior to cessation of Active Work.
 - c) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period already served under the policy and the Portability Privilege. The Employee's original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
 - d) Coverage under the Portability Privilege must terminate immediately prior to the date of Individual Reinstatement under the policy.

SECTION 5A - INDIVIDUAL REINSTATEMENT

- 4) If Personal Insurance terminates because of a leave approved by the Policyholder under the Federal Family and Medical Leave Act (FMLA), or similar applicable state law, and the Employee returns to full-time Active Work immediately following the end of the leave:
 - a) Personal Insurance will become effective immediately upon the date of request for Individual Reinstatement.
 - b) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period previously served under the policy. However, the days accumulated during the period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
 - c) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class that the Employee would have been entitled to prior to the FMLA leave.
- 5) If Personal Insurance terminates because an Employee became a full-time member of the armed forces of the United States and he returns to full-time Active Work, the Person's coverage may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law.

**SECTION 5B - CONTINUATION OF PERSONAL INSURANCE
UNDER THE FAMILY AND MEDICAL LEAVE ACT**

CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT. If the Policyholder correctly approves a leave of absence under the Federal Family and Medical Leave Act (FMLA), a Person's coverage under the policy will be continued as stated in this Section. Personal Insurance will continue while a Person's leave is covered under FMLA, until the end of the later of:

- 1) the leave period permitted under FMLA or
- 2) the leave period permitted by applicable state law.

Coverage continued under this Section is subject to the following requirements:

- 1) the Policyholder has approved a Person's leave in writing as a leave taken under FMLA;
- 2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 - PREMIUM PAYMENT); and
- 3) Basic Weekly Earnings will be the amount as last reported to AUL in writing and in effect prior to the date the Person's family or medical leave began.

Continuation of Personal Insurance under this provision will cease on the earliest of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

**SECTION 5C - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF**

LEAVE OF ABSENCE references in this Section means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance and in writing by the Policyholder and includes temporary layoffs unless otherwise stated.

CONTINUATION OF PERSONAL INSURANCE WHILE TEMPORARILY LAID OFF. If the Policyholder approves a temporary layoff, a Person's coverage under the policy will be continued to the end of the Coverage Month following the month in which the layoff begins, as long as premiums continue to be paid to and received by AUL, subject to same requirement as a Leave Of Absence.

CONTINUATION OF PERSONAL INSURANCE UNDER A LEAVE OF ABSENCE: If the Policyholder approves a Leave of Absence, a Person's coverage under the policy will be continued to the end of the Coverage Month following the month that a Person begins a Leave of Absence as long as premiums continue to be paid to and received by AUL, subject to the following requirements:

- 1) the Policyholder has approved a Person's Leave of Absence in writing;
- 2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 – PREMIUM PAYMENT); and
- 3) Basic Weekly Earnings will be the amount last reported to AUL in writing and in effect prior to the date the Person's Leave of Absence began.

Continuation of Personal Insurance under this provision will cease on the EARLIEST of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

**SECTION 5C - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF**

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

**SECTION 5D - CONTINUATION OF PERSONAL INSURANCE
DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE**

LEAVE OF ABSENCE means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance in writing by the Policyholder.

CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE: If the Person is on a Leave of Absence for Active Military Service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law, the Person's coverage may be continued until the LATER of:

- 1) the length of time the coverage may be continued under the policy for an FMLA leave of absence; or
- 2) the length of time the coverage may be continued under the policy for a Leave of Absence other than an FMLA leave of absence.

Coverage continued under this Section is subject to the following requirements:

- 1) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 - Premium Payment); and
- 2) Basic Weekly Earnings will be the amount last reported to AUL in writing and in effect prior to the date the Person's Leave of Absence for Active Military Service began.

Continuation of Personal Insurance under this provision will cease on the earliest of the following:

- 1) the date a Person dies;
- 2) the date a Person's coverage terminates for nonpayment of premiums;
- 3) the date a Person begins full or part-time employment with another employer;
- 4) the date the policy terminates;
- 5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
- 6) the date a Person's class is no longer offered under the policy;
- 7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits; or
- 8) the date a Person requests termination of coverage under the policy, but not prior to the date of request.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

- 1) the Actively at Work definition; and
- 2) the applicable number of hours needed to meet the requirement for Full-Time Employee, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

SECTION 6 - PREMIUM PAYMENT

PREMIUM PAYMENTS: As provided in the Application, the Policyholder is responsible for properly and accurately paying premiums to AUL on or before the Due Date. All premiums will be calculated and paid in U.S. dollars. At the request of the Policyholder and AUL's written approval, the interval of premium payments may be changed.

Overpayment of premium will not result in increases in any coverage amounts or additional benefits for the Policyholder or Person. If a Person has contributory insurance, premiums paid by the Person may be paid by means of payroll deduction administered by the Policyholder.

Premiums for a Person's coverage under the policy shall be owed beginning on the Person's Individual Effective Date of Insurance. Premiums will cease to be owed on the Person's individual termination date. However, premiums will continue to be owed for a Disabled Person who ceases work. Premiums will continue to be owed until the date they are waived according to the Waiver of Premium provision.

Monthly premiums for each Person will change automatically following attainment of each new age bracket. Each premium payment will include adjustments in past premiums for changes that have not previously been taken into account. Payment of any premium does not maintain the insurance in force beyond the end of the period for which it has been paid. Each premium payment is owed to AUL on or before its Due Date.

PREMIUM RATES: AUL reserves the right to change premium rates on any date:

- 1) after the Policyholder's coverage has been in effect for one year, by giving prior written notice to the Policyholder at least 31 days before the effective date of the change;
- 2) the eligibility or benefit provisions are changed;
- 3) the number of Persons insured through the Policyholder changes by 25% or more;
- 4) a division, unit, subsidiary or affiliate is added to, or deleted from, the Policyholder's coverage under the policy;
- 5) if the age or any other fact that affects the benefits for a Person or Policyholder has been misstated; or
- 6) there is a change in existing laws which affects the coverage offered under the policy.

WAIVER OF PREMIUM: Premium payments will be waived for a Disabled Person beginning with the first day of Disability. Premiums will continue to be waived during any period that benefits are paid to a Person insured by the policy or any AUL Group Long Term or Short Term Disability Income policy if those policies were made available to the Person through employment with the Policyholder. Premiums for coverage under the policy will be waived as described in this provision, provided the Disability claim is approved by AUL. If a Disabled Person returns to work before the end of his Elimination Period or his Benefit Eligibility Period, his premium payments will resume, but he will not be required to repay the waived premiums.

SECTION 7 - GENERAL POLICY PROVISIONS

AGENCY: For all purposes of the policy, the Policyholder acts on behalf of itself or as agent for the Person. Under no circumstances will the Policyholder be deemed the agent of AUL.

AMENDMENT AND CHANGES: The policy may be amended in writing by mutual agreement between the Policyholder and AUL, but without prejudice to any loss incurred prior to the effective date of the amendment. No change in the policy is valid until approved by the Chief Executive Officer, President or Secretary of AUL. No agent has the authority to approve coverage, change the policy or waive any of its provisions.

ASSIGNMENT: No assignment of any present or future right or benefit under the policy will bind AUL without its prior written consent and when permitted under applicable laws.

CERTIFICATES: AUL will issue a certificate for delivery by the Policyholder to the insured Persons. The certificate will summarize the Person's coverage under the policy and will state:

- 1) the benefits provided; and
- 2) to whom the benefits are payable.

If there is any discrepancy between the provisions of any marketing materials, plan documents, certificate, and the provisions of the policy, the provisions of the policy will govern.

CLERICAL ERROR: If a clerical error is made in keeping records on the coverage under the policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise terminated, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy.

CONFORMITY WITH STATE LAWS: Any provision of the policy in conflict with the laws of the state in which it is delivered, is amended to conform to the minimum requirements of those laws.

DATA AND RECORDS: The Policyholder must promptly furnish all information/documentation that AUL reasonably requires. The Policyholder must furnish all relevant information to AUL about Persons:

- 1) who qualify to become insured or are eligible for benefits; and/or
- 2) whose amounts of insurance change; and/or
- 3) whose insurance terminates.

At any reasonable time, AUL or its representatives shall have the right to inspect the records of the Policyholder that, in the opinion of AUL, may have a bearing on the insurance coverage provided under the policy.

SECTION 7 - GENERAL POLICY PROVISIONS

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if AUL (or its third party administrator) decides in its discretion that the Person is entitled to them. Except for the functions the policy explicitly reserves to the Policyholder, AUL (or its third party administrator) reserves the right to:

- 1) manage the policy and administer claims under it; and
- 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:

- 1) establish and enforce procedures for administering the policy and claims under it;
- 2) determine Employees' eligibility for coverage and entitlement to benefits;
- 3) determine what information it reasonably requires to make such decisions; and
- 4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator.

ENTIRE CONTRACT: The policy, the application/enrollment forms of the Persons, the Application of the Policyholder, and any amendments made from time to time constitute the entire contract.

GRACE PERIOD: If the Policyholder or AUL does not give notice in writing that coverage under the policy is to be terminated due to unpaid premium, a Grace Period of 31 days will be granted for the payment of any premium owed after the first premium Due Date. During the Grace Period, the policy will continue in force but will automatically terminate on the last day of the Grace Period. The Policyholder is liable to AUL for payment of premiums for the days of grace during which the policy remains in force. AUL is not obligated to pay claims incurred during the Grace Period until the premium owed is received.

INSURANCE FRAUD: AUL wants to ensure that its customers do not incur additional insurance costs as a result of the act of insurance fraud. Applicable state laws require AUL to undertake measures to detect, investigate and pursue prosecution for fraud.

Anyone that knowingly completes an application for insurance or statement of claim containing any materially false information or facts, with the intent to deceive, conceal or mislead is committing a fraudulent insurance act. This is a crime and may subject such Persons to criminal and civil penalties.

MISSTATEMENT OF FACTS: If the age or any other fact that affects the benefits for a Person or Policyholder has been misstated, the benefits will be payable based on the true facts. Premium adjustment will be made so that AUL will receive the actual premium required based on the true facts.

SECTION 7 - GENERAL POLICY PROVISIONS

REHABILITATION: The goal of a rehabilitation program is to enable the Person to return to work. The Person may choose to join a vocational rehabilitative program while receiving Disability benefits, if prior approval is given in writing by AUL. If the program is approved in advance by AUL, such participation will not alone be deemed recovery from Disability. By mutual written agreement, AUL may help pay the Person's expenses for taking part in the rehabilitation program. Rehabilitation is strictly voluntary and there is no penalty for refusal.

RELATIONSHIP: AUL and the Policyholder are, and will remain, independent contractors. Nothing in the policy or the Application shall be construed as making the parties joint venturers or as creating a relationship of employer and employee, master and servant or principal and agent. Neither party has any power, right or authority to bind the other or to assume or create any obligation or responsibility on behalf of the other. AUL and the Policyholders each retain exclusive control of their time and methods to perform their respective duties. AUL and the Policyholder will employ, pay and supervise their own employees and pay their own expenses. The Policyholder is required to familiarize itself with all relevant state and federal laws including applicable banking, MEWA, plan sponsor, plan administrator, and fiduciary laws. Any violation of federal or state law will require Policyholder to reimburse AUL for any and all damages or fines imposed on AUL as well as AUL's reasonable attorney's fees incurred due to Policyholder's violations and/or any violations incurred by any representative of Policyholder, in which AUL is made party thereof.

STATEMENTS MADE IN AN APPLICATION: all statements in an application or Group Statement of Insurability made by the Policyholder or insured Persons shall be deemed representations and not warranties. No such statements will be used to reduce or deny any claim or to cancel the Person's coverage unless:

- 1) the statement is in writing; and
- 2) a copy of that statement is given to the Person or to his personal representative.

INCONTESTABILITY: The validity of any coverage under the policy may not be contested, except in the case of fraud or for nonpayment of premiums, after the Personal Insurance has been in force for 2 years from the Person's Individual Effective Date of Insurance. Additionally, if the validity of any coverage under the policy is contested due to a misrepresentation of a material fact during the first 2 years after the Person's Individual Effective Date of Insurance, no statement made by a Policyholder or a Person relating to his insurability may be used in contesting the validity of the insurance unless the statement is contained in a written instrument signed by the Person.

All statements made by a Policyholder or a Person are to be deemed representations and not warranties, and that other than a misrepresentation of a material fact no statement made by any Person may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Person or, in the event of death or incapacity of the Person, to the Person's personal representative.

Notwithstanding the foregoing, AUL is not precluded from asserting at any time any defenses based upon provisions in the policy relating to eligibility for coverage.

WORKERS' COMPENSATION AND WORKMEN'S COMPENSATION NOT AFFECTED: The policy is not in lieu of, and does not affect any requirement for coverage by Workers' or Workmen's Compensation Insurance.

SECTION 7A - CLAIM PROCEDURES

INITIAL NOTICE OF DISABILITY: Written notice of Disability must be given to AUL during the Elimination Period. If written notice cannot be made during the Elimination Period without the fault of the claimant, AUL must be notified as soon as it is reasonably possible to do so. Written notice should contain sufficient information to identify the Person. Notices are not considered given until received by AUL at its Home Office in Indianapolis, Indiana, by one of its Claims offices, or by its third party administrator.

CLAIM FORMS FOR PROOF OF LOSS: Upon receipt of the Initial Notice of Disability, AUL will furnish the Policyholder with any necessary claim forms to be given to the Person. These forms must be properly, accurately and truthfully completed and returned to AUL or its third party administrator. If, for any reason, the Person does not receive a claim form within 15 days of request, the Person should submit written proof of Disability. The initial claim form or proof of Disability must show:

- 1) the claimant's name;
- 2) the Employer's name and address;
- 3) the policy number;
- 4) the date Disability started;
- 5) the cause of Disability;
- 6) the nature and extent of the Disability;
- 7) that the claimant is under the appropriate care of a doctor;
- 8) the appropriate documentation of the claimant's earnings and activities; and
- 9) the name and address of any hospital, health provider, health facility or institution where the claimant has received treatment, including the names of all attending and treating doctors.

The initial claim form or proof of Disability must be signed by a Physician and sent to AUL within 90 calendar days of the end of the Elimination Period. If it is not possible to give proof within these limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required.

AUL will also periodically send the Person additional claim forms or requests for information necessary to determine eligibility for benefits under the policy. These subsequent completed claim forms and requests for information must be returned to AUL within 30 days after the Person receives them. If requested forms and/or information are not received from the Person, AUL reserves the right to deny continued benefits for failure to provide proof of continuous disability as required by the policy.

PHYSICAL EXAMINATION: AUL, at its own expense, has the right to have a Person examined, hospitalized and/or tested to determine the existence of any Disability that is the basis for a claim. This right may be exercised as often as is reasonably necessary, as determined by AUL, and must be performed by a Physician of AUL's choice. If the Person fails to comply with AUL's requests for Physical Examination, AUL reserves the right to deny benefits.

SECTION 7A - CLAIM PROCEDURES

LEGAL ACTION: No legal action may be brought to obtain benefits or a refund of premium paid under the policy:

- 1) for at least 60 days after proof of loss or entitlement to a premium refund has been furnished;
- 2) before any denial or reduction of benefits by AUL has been appealed properly in writing; or
- 3) beyond the expiration of the applicable statute of limitations from the time proof of loss or entitlement to a premium refund is required to be given. If no statute of limitations is given, then after 3 years following the expiration of the time within which proof of loss or entitlement to a premium refund is required by the Policyholder.

TIME OF PAYMENT OF CLAIMS: When AUL receives a claim form or proof of Disability, benefits payable under the policy will be paid weekly during any period for which AUL is liable.

PAYMENT OF CLAIMS: All benefits, other than any survivor benefits, are payable to a Person. If a Person dies before a benefit to which he was entitled is paid, AUL has the right to pay up to \$10,000 to any of the Person's relatives to whom AUL considers entitled to such benefits. If AUL pays benefits in good faith to a person who it considers entitled to such benefits, then AUL will have no obligation to pay such benefits again. The Weekly Benefit will be calculated and paid in United States dollars, and when necessary, it will be based on the exchange rate effective on the first day of the Elimination Period.

SECTION 7A - CLAIM PROCEDURES

RIGHT TO APPEAL: When the policy is governed by ERISA, if a Person wishes to appeal the decision made by AUL or its third party administrator, claimants are allowed 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants are allowed the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. 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. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of 29 C.F.R. § 2560.503-1. AUL's review will take into account all written 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 benefit determination. A claimant has a right to obtain the information about any voluntary appeal procedures offered by the plan described in paragraph (c)(3)(iv) of 29 C.F.R. § 2560.503-1 and has a right to bring an action under section 502(a) of ERISA. A final determination will be provided pursuant to 29 C.F.R. § 2560.503-1.

RIGHT OF RECOVERY: If benefits have been received for which the Person was not entitled to receive under the policy, then full reimbursement to AUL is required. Such reimbursement is required whether the overpayment is due to intentional or innocent misrepresentations by the Person, intentional or innocent misrepresentations by an entity supplying AUL with information, a claims processing error or miscalculation by AUL or for any other reason. If reimbursement is not made, then AUL has the right, as allowed under law to:

- 1) reduce future benefits or any amounts payable under all other AUL insurance contracts insuring the Person until full reimbursement is made, and
- 2) recover such overpayments from the Person or his estate.

If AUL chooses not to use benefit payments towards the reimbursement, this will not constitute a waiver of AUL's rights to reimbursement. This provision will be in addition to, and not in lieu of, any other compensation available to AUL by law.

SUBROGATION RIGHTS: AUL has the right to be subrogated to any rights a Person may have against a Third Party. AUL may, at its option, bring legal action to recover benefits it paid in connection with a Person's Disability. AUL may do this if a Person:

- 1) suffers a Disability and, because of any act or omission of a Third Party, becomes entitled to and is paid benefits under the policy; and
- 2) does not initiate legal action for the recovery of such benefits from the Third Party within a reasonable period of time.

SECTION 8 - INSURING PROVISIONS

WEEKLY BENEFIT PAYMENTS: AUL will pay Disability benefits, according to the policy, if a Person becomes Disabled while insured by the policy. AUL must receive proof that a Person is Disabled due to Sickness or Injury and requires the Regular Attendance of a legally qualified Physician. AUL will pay the Person a Weekly Benefit after the Person satisfies the Elimination Period. The Elimination Period may be satisfied by Total Disability, Partial Disability, or a combination of both.

The Weekly Benefit will be paid as long as Disability continues; provided that proof of continued Disability is submitted to AUL upon request and the Person is under the Regular Attendance and care of a Physician. The proof must be submitted at the Person's expense. Weekly Benefits will not be paid during any period that a Person is incarcerated in a penal or correctional institution.

The Weekly Benefit will not exceed the Maximum Weekly Benefit, nor will it be payable for longer than the Maximum Benefit Duration. The Maximum Weekly Benefit and the Maximum Benefit Duration are stated in the Schedule of Benefits.

PRORATING OF THE WEEKLY BENEFIT: The eligible Weekly Benefit will be paid on a weekly basis. For any period of Disability less than one week, the Weekly Benefit payment will be paid on a pro-rata basis at the rate of 1/7 per day.

REDUCTIONS TO THE WEEKLY BENEFIT: Other Income Benefits will reduce the Weekly Benefit as defined in this certificate. The Social Security Integration Method used is stated in the Schedule of Benefits.

SECTION 8 - INSURING PROVISIONS

WEEKLY BENEFITS: To figure the amount of the Total Disability Benefit if a Direct Primary or Family Social Security integration method is stated on the Schedule of Benefits, take the Person's Weekly Benefit and reduce the result by Other Income Benefits.

SECTION 8 - INSURING PROVISIONS

LUMP SUM PAYMENTS: Other Income Benefits that are paid in a lump sum, excluding benefits received from the Employer's Retirement Plan, will be prorated by AUL over the stated period of time the lump sum was projected to apply. Lump sums projected to cover the Person's life expectancy will be prorated based on appropriate actuarial tables. If the projected period of time that a lump sum is intended to cover is not stated, the lump sum will be prorated over a period of 60 months.

A lump sum payment from an Employer's Retirement Plan will be prorated over 60 months. However, if such lump sum is rolled to an annuity or retirement account that does not pay a benefit prior to the end of the Maximum Benefit Duration stated in the Schedule of Benefits, then the Gross Monthly Benefit will not be reduced by that lump sum payment.

Regardless of how benefits from the Employer's Retirement Plan are distributed, AUL will treat contributions made by the Person and Policyholder as if they were distributed simultaneously throughout the Person's lifetime.

APPLICATION FOR OTHER INCOME BENEFITS: If the Person, Spouse or Child(ren) are or become eligible for any Other Income Benefit, they must:

- 1) apply for the Other Income Benefits; and
- 2) appeal any denial for the Other Income Benefits that appears unreasonable.

Until approval or denial of any Other Income Benefits for any Disability is determined, AUL will make payments as indicated below.

AUL will pay the Weekly Benefit after the Elimination Period, with no reduction for estimated benefits until the appropriate entity has reached a decision. When a decision is reached, the Person must send AUL a copy of the determination and reimburse AUL for any overpayment made as a result of that decision, regardless of whether or not the coverage is still in force on the date the Person recovers such amount.

Additionally, if an award is made, AUL will reduce the Weekly Benefit by the amount of the Other Income Benefits the Person received, in accordance with the terms of the policy.

SECTION 8 - INSURING PROVISIONS

SOCIAL SECURITY APPLICATION ASSISTANCE. When AUL determines that a Person is a likely candidate for Social Security Disability Insurance (SSDI), AUL may assist the Person with the application process for these benefits.

Upon written request, a representative from AUL's Group Claims Department may supply pertinent information to the Person about:

- 1) eligibility for SSDI benefits;
- 2) how to begin the application process;
- 3) how to submit an appeal;
- 4) guidelines established by the Social Security Administration for submitting appeals; and
- 5) names of organizations offering assistance.

SECTION 8 - INSURING PROVISIONS

MINIMUM WEEKLY BENEFIT: While a Weekly Benefit is payable under the policy, the Weekly Benefit shall not be reduced to an amount less than the Minimum Weekly Benefit indicated in the Schedule of Benefits.

COST OF LIVING ADJUSTMENT FREEZE: If the Person receives a cost of living increase, with regard to Other Income Benefits, after the date benefits actually become payable under the policy, the Weekly Benefit will not be further reduced by such cost of living increase. For purposes of this provision, a cost of living increase is any annual increase reasonably related to the annual increase in any generally recognized cost of living measurement that applies to all Persons who are entitled to receive such benefits.

TERMINATION OF THE WEEKLY BENEFIT: The Weekly Benefit will cease on the EARLIEST of the following:

- 1) the date Current Weekly Income equals or exceeds 80% of the Indexed Pre-disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration stated in the Schedule of Benefits is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive Weekly Benefit payments.

SECTION 8 - INSURING PROVISIONS

RESIDUAL BENEFIT: If the residual benefit is elected by the Policyholder, then the Elimination Period can be met using Total Disability, Partial Disability, or a combination of both.

RECURRENT DISABILITY: If, after a period of Disability for which benefits are payable, the Person resumes his Regular Job as a Full-Time Employee and performs each Material and Substantial Duty of that Job for 30 consecutive days of full-time work, any Recurrent Disability will be part of a new period of Disability and a new Elimination Period must be completed before any further Weekly Benefits are payable.

If the Person resumes his Regular Job as a Full-Time Employee and performs each Material and Substantial Duty of that Job for less than 30 consecutive days of full-time work, a Recurrent Disability will be part of the same period of Disability. The Recurrent Disability must be the direct result of the Injury or Sickness that caused the prior Disability. The Person will not have to complete a new Elimination Period. Benefit payments will be subject to the terms of the policy for the prior Disability. The benefit will be based on the amount of Basic Weekly Earnings in effect immediately prior to the original Elimination Period.

In order to prevent over-insurance because of duplication of benefits, benefits payable under the Recurrent Disability provision will cease if benefits are payable to the Person under any other group short term disability policy.

The Recurrent Disability provision in this Section is only applicable as long as the Policyholder's coverage remains in force with AUL.

SECTION 8 - INSURING PROVISIONS

PRESUMPTIVE DISABILITY: When a Person is Partially Disabled and his Current Weekly Income is 20% or less than his Indexed Pre-Disability Earnings, AUL will not reduce the Weekly Benefit by Current Weekly Income.

BENEFITS WHILE PARTIALLY DISABLED: When proof is received that a Person is Partially Disabled, then the Partial Disability Benefit applies. Benefits are payable following completion of the Elimination Period. The Partial Disability must be the direct result of the Injury or Sickness that caused the Disability immediately preceding it.

SECTION 8 - INSURING PROVISIONS

PARTIAL DISABILITY BENEFIT: The benefit for Partial Disability will be calculated as follows:

- 1) Subtract the Person's Current Weekly Income from the Person's Indexed Pre-Disability Earnings.
- 2) Divide the answer in Item 1) by the Person's Indexed Pre-Disability Earnings. The result is the Person's percentage of lost earnings.
- 3) From the Person's Gross Weekly Benefit, subtract any Other Income Benefits;
- 4) Multiply the answer in Item 2) by the answer in Item 3). This is the Person's benefit for Partial Disability.

Benefits for Partial Disability will never exceed the Person's Maximum Weekly Benefit as shown on the Schedule of Benefits, nor be less than the Minimum Weekly Benefit as shown on the Schedule of Benefits. The Partial Disability Benefit will continue as shown above until the EARLIEST of the date:

- 1) the Person ceases to be Partially Disabled;
- 2) the Person dies;
- 3) the Maximum Benefit Duration, as shown on the Schedule of Benefits, is completed;
- 4) the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 5) the Person refuses to allow an examination requested by AUL;
- 6) the Person is no longer under the Regular Attendance and care of a Physician;
- 7) the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 8) the Person leaves the United States or Canada and establishes his residence in another country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive weeks of benefits.

For purposes of the Partial Disability Benefit provision, Pre-Disability Earnings will be increased annually using the Consumer Price Index. The increase will be effective on the July 1st following the first 12 consecutive calendar months of Disability and on each subsequent July 1st. The annual increase is only to determine eligibility and will not increase the Partial Disability Benefit.

AUL may require any evidence needed to verify the Person's earnings and proof of continuing Disability.

SECTION 8 - INSURING PROVISIONS

ORGAN TRANSPLANT PROCEDURE means the surgical removal of any one or more of a Person's organs for the purpose of transplanting to another individual.

ORGAN DONOR TRANSPLANT BENEFIT: AUL will pay a Weekly Benefit if a Person becomes Disabled as a result of an Organ Transplant Procedure while insured under the policy. Proof of the Disability must be received by AUL for review. Payment of this benefit will not be subject to satisfaction of the Pre-Existing Condition exclusion or limitation period.

TERMINATION: The Organ Donor Transplant Benefit will terminate the EARLIER of:

- 1) the date Current Weekly Income equals or exceeds 80% of the Indexed Pre-disability Earnings;
- 2) the date that the Person ceases to be Disabled;
- 3) the date the Person dies;
- 4) the date the Maximum Benefit Duration stated in the Schedule of Benefits is completed;
- 5) the date the Person fails to give AUL required proof of Disability or information required by AUL to determine if any benefits are owed under the policy;
- 6) the date the Person refuses to allow an examination requested by AUL;
- 7) the date the Person is no longer under the Regular Attendance and care of a Physician;
- 8) the date the Person refuses to provide any evidence required by AUL to verify the Person's Current Weekly Income; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for a total period of 26 weeks or more during any 52 consecutive Weekly Benefit payments.

SECTION 9 - EXCLUSIONS

GENERAL EXCLUSIONS: The policy does not cover any Disability caused by, contributed to by, or resulting from:

- 1) participation in war or any act of war, declared or undeclared;
- 2) active participation in a riot;
- 3) attempted suicide, regardless of mental capacity;
- 4) attempted or actual self-inflicted bodily injury or self destruction, including but not limited to the voluntary inhaling or taking of:
 - a) a prescription drug in a manner other than as prescribed by a Physician;
 - b) any federal or state regulated substance in an unlawful manner;
 - c) non-prescription medicine in a manner other than as indicated in the printed instructions;
 - d) poison; and
 - e) toxic fumes;
- 5) commission of or attempt to commit a criminal act under relevant state law;
- 6) Cosmetic Surgery. However, Cosmetic Surgery will be covered when it is due to:
 - a) reconstructive surgery incidental to, or follows surgery resulting from, trauma, infection or other diseases of the involved part; or
 - b) congenital disease or anomaly that has resulted in a functional defect;
- 7) a Person being legally intoxicated as defined by the law of the jurisdiction in which the incident occurs;
- 8) any event that occurs while a Person is incarcerated in a penal or correctional institution;
- 9) participation in any self asphyxiation method;
- 10) Surgery that is not Medically Necessary to treat a Sickness or Injury;
- 11) traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes;
- 12) engaging in any illegal or fraudulent occupation, work, or employment; or
- 13) any Injury or Sickness due to employment, and for which benefits are payable by any type of Workers' or Workmen's Compensation Law or any similar act or law.

SECTION 9 - EXCLUSIONS

PRE-EXISTING CONDITION EXCLUSION:

Benefits will not be paid if the Person's Disability begins in the first 12 months following the Person's Individual Effective Date of Insurance; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Person's Individual Effective Date of Insurance.

SECTION 9 - EXCLUSIONS

PRE-EXISTING CONDITION EXCLUSION ON AN INCREASED MAXIMUM WEEKLY BENEFIT: This provision applies to an increase in the Maximum Weekly Benefit that occurs after the Policyholder's Effective Date.

The policy will not cover the amount of the increase in the Maximum Weekly Benefit if the Person's Disability begins in the first 12 months following the effective date of the increase in coverage; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to his effective date of increase in amount of insurance.

PRE-EXISTING CONDITION EXCLUSION FOR A CHANGE IN OPTIONS: This provision applies when a Person changes Options resulting in an increase in coverage after the Policyholder's Effective Date.

The policy will not cover the Person under the new Option if the Person's Disability begins in the first 12 months following the Effective Date of Change in Options; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Effective Date of Change in Options.

A Person will receive benefits based on the Option he was previously insured under if eligible for such benefits according to the provisions applicable to that Option.

SECTION 14 - PORTABILITY PRIVILEGE

If a Person's insurance under the policy terminates for any reason other than stated below, the Person is entitled to continue his coverage for 12 months without submission of Evidence of Insurability. To be eligible for this Privilege, the Person must have been insured under the policy for at least 12 consecutive months just before insurance under the policy terminated.

This Portability Privilege provides the same coverage that the Person had immediately prior to the date of his termination. Any benefits payable are governed by the policy according to the provisions and benefits elected by the Policyholder and stated in the Schedule of Benefits. However, the Maximum Benefit Duration will be the lesser of:

- 1) 2 years; or
- 2) the Maximum Benefit Duration in effect immediately prior to the date of his termination.

This Portability Privilege is subject to the following:

- 1) application for Portability must be made via a method approved by AUL within 31 calendar days after termination of insurance under the policy;
- 2) payment of the initial correct amount of premium;
- 3) the premium is based on the Person's age and the premium rate in effect on the date of application for Portability; and
- 4) the effective date for the Person under the Portability Privilege is the date immediately following the date of his termination.

The Portability Privilege is not available to any Person:

- 1) whose insurance under the policy terminates for any of the following reasons:
 - a) the Person enters a class of Employees that are not eligible for coverage under the policy;
 - b) the Person retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career); or
 - c) the Person failed to pay any required premium;
- 2) who is or becomes insured for any other group long or short term disability policy which provides coverage similar to the type of coverage provided by the policy within 31 days after termination under the policy;
- 3) who is Disabled under the terms of the policy; or
- 4) who is on leave of absence.

Insurance under the Portability Privilege will terminate on the earliest of the following dates:

- 1) the last day for which any required premium has been made;
- 2) the date the Person requests termination, but not prior to the date of the request;
- 3) the last day of a Coverage Month, provided that AUL has given at least 31 days prior written notice to the Person;
- 4) the date the Person retires;
- 5) the date the policy terminates;
- 6) the date the Person enters active military service for any country, except for temporary duty of 30 days or less;
- 7) the date that coverage begins under any other group long or short term disability policy that provides coverage similar to coverage provided by the policy;
- 8) the date following 12 months of coverage; or
- 9) the date the Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been outside the United States or Canada for more than 6 months in any 12 month period.

SECTION 16A - VOCATIONAL REHABILITATION PROGRAM

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by AUL, prepares in accordance with this Vocational Rehabilitation Program section.

VOCATIONAL REHABILITATION PROGRAM: AUL's Vocational Rehabilitation Program is designed to assist a Person in returning to work. A Person's claim is reviewed and medical and vocational information is analyzed to determine if rehabilitation services might assist in this process.

AUL's Rehabilitation Program specialists, who coordinate with a Person's Physician and other specialists, complete an initial review. After this review, AUL may elect to offer and pay for a reasonable and necessary Vocational Rehabilitation Program. A Person must receive written approval from AUL, and a Vocational Rehabilitation Plan must be developed for the Person, before he is eligible for services under this provision. AUL will not reimburse unapproved or unnecessary rehabilitation expenses.

AUL's Vocational Rehabilitation Program may include coordination with other parties to:

- 1) assist in a Person's return to work;
- 2) evaluate adaptive equipment to allow a Person to work;
- 3) provide child care assistance during a Person's participation in a rehabilitation program;
- 4) provide vocational evaluation;
- 5) provide job placement services;
- 6) provide resume preparation;
- 7) provide job-seeking skills training;
- 8) provide retraining for a new occupation;
- 9) provide alternative treatment plans such as recommendations for:
 - a) support groups;
 - b) physical therapy;
 - c) occupational therapy;
 - d) speech therapy;
 - e) exercise programs;
 - f) mental health programs; or
 - g) other medical rehabilitation programs.

SECTION 17 - WORKPLACE MODIFICATION BENEFIT

WORKPLACE MODIFICATION means reasonable and necessary changes to a Person's work environment or to the way a Person's job is performed that enables the Person to return to full or part-time work for the Policyholder.

WORKPLACE MODIFICATION BENEFIT: AUL may pay the expense for any reasonable and necessary modification to a Person's workplace to accommodate the Person's Disability and enable him to return to Active Work for the Policyholder. The amount AUL may pay will not exceed the lesser of:

- 1) 2 times the Person's last Weekly Benefit payment; or
- 2) \$2,000.

To qualify for this Benefit:

- 1) a Person must be receiving a Weekly Benefit under the policy;
- 2) the Policyholder must agree to make reasonable and necessary modifications to the workplace that reasonably accommodates and enables a Person's return to full or part-time employment with the Policyholder; and
- 3) all proposed modifications and costs must be approved by AUL in advance and in writing prior to making any modification.

AUL may evaluate the appropriateness of a proposed modification.

AUL reserves the right, at its expense, to have a Person examined and evaluated by a Physician or other health care professional and a vocational expert or rehabilitation specialist of its choice, as frequently as it deems necessary.

If the Policyholder incurs reasonable and necessary costs for AUL approved modifications, the Policyholder will be reimbursed after:

- 1) proposed modifications made on the Person's behalf are completed;
- 2) written proof of incurred expenses for all modifications have been provided to and approved by AUL; and
- 3) the Person has returned to full or part-time employment with the Policyholder.

This Benefit will not be payable if:

- 1) expenses were not incurred in making the actual modification;
- 2) AUL did not provide written approval for the modification or its cost prior to the expense;
- 3) the Person becomes self-employed or returns to work for an employer other than the Policyholder;
- 4) the Person or Policyholder is able to apply or receives reimbursement for any costs under any other governmental program, grant, insurance policy, law or settlement; or
- 5) the Person ceases to be Disabled before or during the Workplace Modification.

This benefit is available on a one-time basis, per Person.

**SUMMARY OF THE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
AND
NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS**

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the association.

Coverage

Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

Persons holding such policies or contracts are not protected by this association if:

1. they are not residents of the State of Pennsylvania, except under very specific circumstances;
2. the insurer was not authorized to do business in Pennsylvania at the time the policy or contract was issued;
3. their policy was issued by a nonprofit hospital or health service corporation (e.g. a Blue Cross or Blue Shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

1. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
2. any policy of reinsurance (unless an assumption certificate was issued);
3. plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
4. interest rate yields that exceed an average rate;
5. dividends;
6. experience rating credits;
7. credits given in connection with the administration of a policy or contract;
8. annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
9. policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
10. sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
11. unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
12. financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
13. any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits on Amount of Coverage

The act also limits the amount the association is obligated to pay out; the association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall \$300,000 limit, the association will pay up to \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender or withdrawal values. For annuities, the association will pay up to \$300,000 in annuity benefits, or \$100,000 in net cash surrender or withdrawal benefits. For health insurance, the association will pay up to \$100,000, including any net cash surrender or withdrawal benefits.



Everyone deserves
 a better Tomorrow.

AccidentAdvance® is accident
 insurance with benefits for
 unexpected injuries.

George enrolls himself, his wife and his kids in the accident insurance offered at the car dealership where he works, joking that his wife is such a klutz that they'll get plenty of use out of it. A few weeks later, he drops a cinder block on his foot while working in his garage, breaking a bone. He ends up with a cast, crutches and a joke his wife will never let him live down.

Get benefits to spend on what you need.

George's health insurance pays for many of his medical expenses, but he still has copays and a high deductible. He doesn't make commissions for sales on the days he misses work, and visiting the orthopedic specialist's office 50 miles away costs a lot in gas.

Because he has accident insurance, he has help recovering financially without dipping into their family savings or using a credit card. Accident insurance benefits are paid directly to the insured, letting him use them where and how they're most needed.

Get the benefits that fit your needs.

George gets specific amounts for his emergency care (including X-rays and physician care received within 96 hours of the accident), for follow-up visits and for his physical therapy while recovering. He would have gotten additional help had he needed an ambulance, initial hospitalization or intensive care. See this brochure for in-depth information about what benefits are paid for specific injuries or procedures.

Help protect yourself and your family.

George liked the ability to add his wife and kids to his policy. Because kids can be especially accident-prone, a family accident policy provides extra peace of mind. Employees and their spouses can be insured after reaching age 18, and eligible dependent children can keep their insurance through age 25.

Enjoy our hassle-free online claims process.

Our easy-to-navigate website allows you to update your information, keep track of your policies, submit claims and more from your PC or mobile device.

Up-to-date information regarding our compensation practices can be found in the Disclosure section of our website at tebcs.com.

Product Highlights
Pays benefits directly to you
Family options available
Payroll-deducted premiums

This is a brief summary of AccidentAdvance® accident insurance. Policy form series CPACC100 and CCACC100. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusion apply. Refer to the policy, certificate and riders for complete details.

Product Details

**Plan 6
24 Hour**

Module 1 Accident Emergency Treatment		6.00 Units	
Accident Emergency Treatment Benefit For physician treatment and X-rays in a hospital emergency room or doctor's office within 96 hours of the accident.		\$150	
Major Diagnostic Examination Benefit For one CT Scan, MRI, or EEG completed within 90 days of the accident.		\$240	
Dislocation Benefit Payable for joint dislocation reduced under general anesthesia. Dislocation reduced without general anesthesia paid at 25% of the joint's benefit amount. Multiple reduced dislocations are paid at 1 1/2 times the highest benefit amount. No other amount will be paid under this benefit.	Dislocated Joint	Reduction	
		Open	Closed
	Hip	\$4,800	\$1,620
	Knee or Shoulder	\$1,620	\$660
	Collar Bone	\$2,580	\$480
	Ankle or Foot (except toes)	\$1,620	\$480
	Lower Jaw	\$1,620	\$840
	Wrist or Elbow	\$1,320	\$660
Toe or Finger	\$360	\$180	
Fractures Benefit For repair of a fracture sustained in an accident. A chip fracture is paid at 10% of the fracture's benefit amount. Multiple repaired fractures are paid at 1 1/2 times the highest benefit amount. No other amount will be paid under this benefit.	Fractured Bone	Reduction	
		Open	Closed
	Coccyx	\$840	\$420
	Hand (except fingers), Foot (except toes/heel), Wrist, Shoulder Blade, Forearm, Ankle, Elbow, Kneecap, Sternum or Lower Jaw	\$2,040	\$1,020
	Hip	\$6,000	\$2,040
	Leg	\$2,520	\$2,040
	Nose, Heel or Fingers	\$2,040	\$420
	Ribs	\$4,020	\$420
	Skull	\$3,240	\$1,200
	Toes	\$840	\$420
	Upper Jaw, Upper Arm or Face (except Nose), Collar Bone	\$2,400	\$1,020
	Vertebrae, Pelvis	\$1,020	\$1,020
	Vertebral Processes	\$4,020	\$600

For both dislocations and fractures, 1 1/2 times the highest dislocation or fracture benefit amount is paid. No other dislocation or fracture benefit is paid.

Product Details

Module 2 Follow-Up Visits and Physical Therapy		7.00 Units
Accident Follow-Up Treatment Benefit Maximum of three (3) follow-up visits per accident. Original treatment must have been within 96 hours of the accident. Treatment must be provided by a physician in their office or in a hospital on an outpatient basis; begin within 30 days of, and be completed within the 6 months following the later of: the accident; discharge from the hospital from a covered confinement; or discharge from an extended care facility.		\$70
Physical Therapy Benefit For treatments by a licensed physical therapist under a physician's advice that begin within 120 days of the accident and are completed within 1 year of the accident, not to exceed 10 treatments per accident.		\$70
Module 3 Initial Accident Hospitalization		3.50 Units
Initial Accident Hospitalization Benefit Payable once for the first hospital admission due to an accident. Benefit is payable once for the first Intensive Care Unit admission due to an accident. The ICU benefit is paid even if admitted to the hospital initially and then transferred to ICU later during the same hospitalization.		\$1,050
Ambulance Benefit For transportation to the nearest hospital for treatment within 96 hours of the accident by a licensed ambulance service.	Ground Ambulance	\$210
	Air Ambulance	\$1,050
Additional Riders		
Accident Hospital and ICU Income Rider (Form No. CRHICU00)		8.00 Units
Accident Hospital Income Benefit For hospital confinement for treatment of injuries beginning within 30 days of the accident. Benefit is payable for up to 365 days per accident.		\$200
Accident ICU Benefit For ICU confinement while the person is receiving the hospital income benefit. Benefit is payable for up to 15 days per accident.		\$600

Product Details

Expanded Benefits Rider (Form No. CREXPB00)		6.00 Units
The following benefits are payable once, per person, per accident for injuries sustained in a covered accident.		
Burns Must be treated by a physician within 96 hours of the accident. One or more skin grafts for a covered burn will be paid at 50% of the burn benefit amount paid for the burn involved.	Second-degree burns of body surface: At least 25%, but not more than 35%	\$360
	More than 35%	\$900
	Third-degree burns of body surface: 6 through 10 square centimeters	\$900
	10 through 25 square centimeters	\$2,400
	25 through 35 square centimeters	\$5,400
	more than 35 square centimeters	\$7,200
	Lacerations Must be treated or repaired within 96 hours of the accident.	Lacerations not requiring sutures
Single laceration less than 7.6 centimeters		\$48
Lacerations 7.6 to 20 centimeters		\$180
Lacerations over 20 centimeters		\$360
Eye Injury	With surgical repair	\$240
	Non-surgical removal of foreign body by physician	\$42
Emergency Dental Work	One or more broken teeth repaired with crowns	\$180
	One or more broken teeth resulting in extractions	\$48
Brain Concussion Must be diagnosed by a physician within 96 hours of the accident.		\$120
Coma Unconsciousness for 14 consecutive days with no reaction to external stimuli, no reaction to internal needs and require the use of life support systems.		\$9,000
Paralysis Lasting a minimum of 30 days	Quadriplegia (paralysis of four limbs)	\$9,000
	Paraplegia (paralysis of lower limbs)	\$4,500
Tendons, Ligaments and/or Rotator Cuffs Must be detached, torn, ruptured or severed and surgically repaired by a physician within one (1) year of the accident. Only one of the benefits is payable.	Arthroscopic surgery with: No repair	\$120
	One repair	\$300
	Two or more repairs	\$600
Ruptured Discs and/or Torn Knee Cartilage Must be surgically repaired by a physician within one (1) year of the accident. Only one of the benefits is payable.	Shaved cartilage or arthroscopic surgery with: No repair	\$120
	One repair	\$300
	Two or more repairs	\$600

Product Details

Major Surgery For an open abdominal, cranial or thoracic surgery performed by a physician within 1 year of the accident. Laparoscopic procedures are excluded.		\$900
Appliance For a physician-recommended medical appliance to aid personal locomotion, such as crutches, leg braces, wheelchairs and walkers. This benefit is not payable for prosthetic devices.		\$120
Prosthetic Devices For one or more prosthetic devices received within 1 year of the accident. This benefit is not payable for hearing aids, dental aids (including false teeth), glasses, cosmetic prosthetic devices, such as wigs, or joint replacement, such as an artificial hip or knee.	One prosthetic device	\$450
	Two or more prosthetic devices	\$900
Blood, Plasma and Platelets Required for the treatment of injuries due to a covered accident. Immunoglobulin is not covered.		\$240
Transportation Benefit is payable for up to 2 round trips to the hospital per accident per insured person if special treatment and hospital confinement occurs within 30 days of the accident. The local attending physician must prescribe treatment that is not available locally. Benefit is not payable for transportation to any hospital within a 100-mile radius of the accident site or insured person's residence.		\$360
Family Lodging Benefit Benefit is payable per day, maximum of 30 days, for one motel/hotel room for a member of the immediate family to accompany the insured person for treatment of injuries prescribed by a physician. Hospital confinement must be in a facility at least 100 miles from the insured person's residence and confinement must begin within 30 days of the accident. Benefits are not payable for services rendered by an immediate family member.		\$90

Product Details

Rates					Ver 3.0.PA.0.00
Accident Insurance	Rate Frequency	Employee	Employee and Child(ren)	Employee and Spouse	Employee, Spouse and Child(ren)
Plan Option I 24 Hour	Weekly	\$2.97	\$4.07	\$4.62	\$5.81

**HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.*

Issue State: Pennsylvania
Rate generation date: January 9, 2018

Limitations and Exclusions

We will not pay benefits for losses caused by or as a result of an insured person:

- Driving any taxi for wage, compensation or profit;
- Mountaineering, parachuting or hang gliding;
- Voluntarily taking, administering, absorbing or inhaling poison, gas or fumes;
- Alcoholism or drug addiction;
- Participating in any sport or sporting activity for wage, compensation, profit, or racing any type of vehicle in an organized event;
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
- War, or any act of war, whether declared or undeclared;
- Participating in a riot, civil commotion, civil disobedience or unlawful assembly;
- A Covered Person's committing or attempting to commit a felony or engaging in an illegal occupation;
- Intentionally self-inflicting a bodily injury or attempting suicide;
- Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no insurance is provided as a result of this exception.

Termination of Insurance

Subject to the Portability Option, insurance on the employee will end on the earliest of:

- the date of his or her death;
- the date he or she ceases to be eligible for insurance;
- the last date for which premium payment has been made to us, subject to the grace period;
- the date he or she terminates employment;
- the date the group master policy terminates;
- the date he or she sends us a written notice to cancel insurance.

The insurance on a dependent will cease on the earliest of:

- the date of the employee's death;
- the date the employee's insurance terminates;
- the last date for which premium payment has been made to us, subject to the grace period;
- the date the dependent no longer meets the definition of dependent;
- the date the certificate is modified so as to exclude dependent insurance;
- the date the employee sends us a written notice to cancel insurance on a dependent.

Extension of Benefits

Whenever termination of insurance under this section occurs due to termination of employment, such termination will be without prejudice to:

- any hospital confinement which began while insurance was in force; or
- any covered treatment or service for which benefits would be provided and which began while insurance was in force; provided, however that the insured person is and continues to be hospital confined or receiving treatment.

Such Extension of Benefits will continue for up to the earlier of:

- 30 days; or
- the date on which the insured person is no longer hospitalized or receiving treatment.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue your insurance.

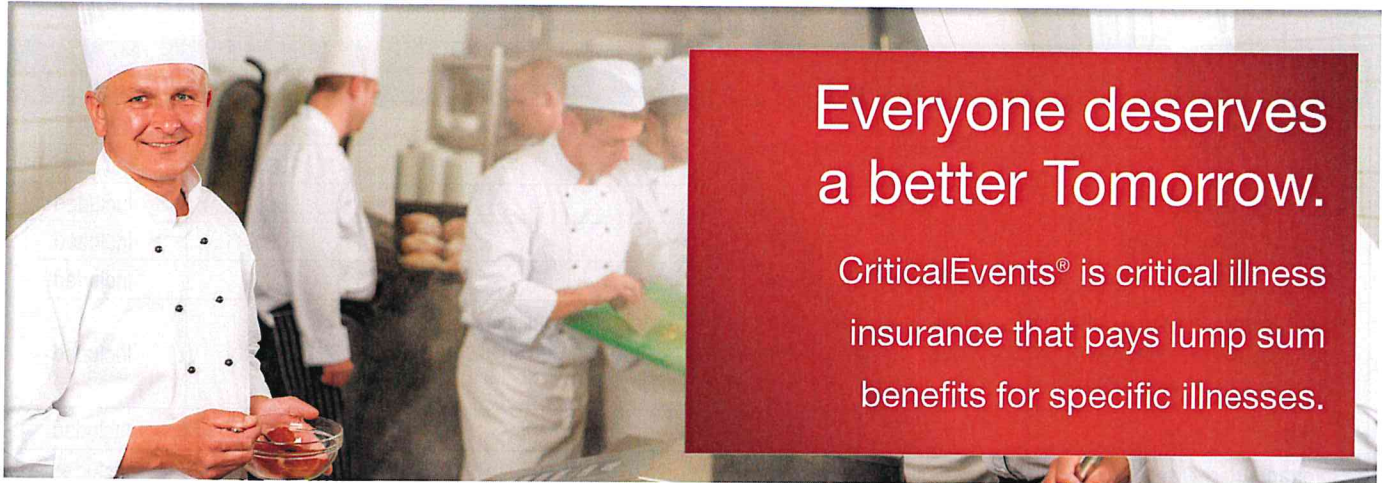
Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Limitations and Exclusions

Other Insurance with Us

An individual can only have one accident policy or certificate with us. An individual can only have one disability income policy, certificate, or rider with us. If a person already has accident insurance with us, such person is not eligible to apply for this insurance. If a person already has disability income insurance with us, such person is not eligible to apply for the disability income riders.



Everyone deserves
a better Tomorrow.

CriticalEvents® is critical illness
insurance that pays lump sum
benefits for specific illnesses.

Ed, a sous chef, signs up for his employer's critical illness insurance because his dad and grandfather had heart disease. He figures his fondness for steak and watching TV from his recliner aren't helping his health, either.

It pays to be ready.

When Ed has a heart attack and then bypass surgery, he's relieved his critical illness insurance pays a lump sum benefit. He doesn't have to use his retirement savings to cover missed work income, drives to the heart hospital and medical insurance deductibles.

You can't predict a critical illness like a heart attack, stroke or cancer, but you can prepare for the potential financial impact. Critical illness insurance can help ease financial stress with lump-sum cash benefits used however you see fit.

Money for what you need most.

Ed's costs add up faster than he expected, so he uses his critical illness insurance benefit payment for costs like:

- deductibles, co-pays, and his hospital bill
- his plane ticket to a specialized heart hospital
- the mortgage on his house while he's not bringing in income
- credit card payments and his utility bills
- day care costs for his two kids

Take our portable policy with you.

Several years later, Ed is offered the head chef position at another restaurant and gladly accepts the new job. He begins paying premiums directly to Transamerica so he can keep his policy.

Keep your insurance when changing jobs by opting to pay premiums directly to us within 31 days of leaving your current job. Let us know you want to continue your critical illness insurance policy, and we'll bill you directly.

Enjoy our hassle-free claims process.

Our easy-to-navigate website allows you to manage your information, policies and claims from your PC or mobile device.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.

Product Highlights
No lifetime maximum
No waiting period
Benefits paid directly to you
Payroll-deducted premiums
Family options available

Product Details

An employee may purchase a benefit amount based on the premiums as shown in the following pages. A spouse and child dependent amount will be a percentage of the employee-elected amount. Employees and spouses are eligible at age 18 and up, eligible children from birth through age 25.

Base Policy Benefits	Percentage of Benefit	Plan Option 1
Heart Attack	100%	Included
Stroke	100%	Included
Major Organ Failure	100%	Included
End Stage Renal Failure	100%	Included
Other Specified Organ Failure (Loss of sight, speech, or hearing)	100%	Included
Miscellaneous Diseases - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Encephalitis/meningitis, Rocky Mountain Spotted Fever, Typhoid Fever, Anthrax, Cholera, Primary Sclerosing Cholangitis (Walter Payton's Disease) and Tuberculosis	100%	Included
Alzheimer's Disease	30%	Included
Coronary Artery Disease Requiring Bypass Grafts	25%	Included
Coronary Artery Disease Requiring Angioplasty/Stent	5%	Included

	Plan Option 1
Dependent Insurance	50%
First Occurrence	First occurrence after effective date
Rate Structure	Voluntary - Issue Age

Cancer Benefit Rider	Percentage of Benefit	Plan Option 1
Invasive Cancer	100%	Included
Bone Marrow Failure	100%	Included
Carcinoma In Situ	25%	Included
Prostate Cancer with TNM Classification of T1	25%	Included
Skin Cancer	5%	Included

Additional Benefit	Plan Option 1
Wellness Indemnity Benefit Rider	\$50
Recurrent Critical Illness Benefit Rider	50%

Product Details

Plan Option 1 Weekly Non-Tobacco Issue Age Rates

Critical Illness Benefits: Heart Attack, Stroke, Major Organ Failure, End Stage Renal Failure, Other Specified Organ Failure (Loss of sight, speech, or hearing), Miscellaneous Diseases, Alzheimer's Disease, Coronary Artery Disease Requiring Bypass Grafts, Coronary Artery Disease Requiring Angioplasty/Stent

Optional Riders: Cancer Benefit Rider, Recurrent Critical Illness Benefit Rider (50%) and Wellness Benefit Rider (\$50)

Employee			Ver 4.0.ND.PA.0.00.FA
Age	\$15000	\$20000	
18-29	\$2.96	\$3.64	
30-39	\$3.41	\$4.24	
40-49	\$5.87	\$7.52	
50-59	\$10.30	\$13.43	
60-64	\$21.10	\$27.83	
65+	\$24.87	\$32.86	
1 Parent Family			
18-29	\$3.20	\$3.91	
30-39	\$3.65	\$4.51	
40-49	\$6.11	\$7.78	
50-59	\$10.54	\$13.69	
60-64	\$21.34	\$28.09	
65+	\$25.11	\$33.12	
2 Parent Family			
18-29	\$4.15	\$5.01	
30-39	\$5.05	\$6.21	
40-49	\$8.75	\$11.15	
50-59	\$14.78	\$19.18	
60-64	\$31.05	\$40.88	
65+	\$34.26	\$45.17	

Issue State: Pennsylvania

Rate generation date: January 25, 2018

**HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.*

Product Details

Plan Option 1 Weekly Tobacco Issue Age Rates

Critical Illness Benefits: Heart Attack, Stroke, Major Organ Failure, End Stage Renal Failure, Other Specified Organ Failure (Loss of sight, speech, or hearing), Miscellaneous Diseases, Alzheimer's Disease, Coronary Artery Disease Requiring Bypass Grafts, Coronary Artery Disease Requiring Angioplasty/Stent

Optional Riders: Cancer Benefit Rider, Recurrent Critical Illness Benefit Rider (50%) and Wellness Benefit Rider (\$50)

Employee			Ver 4.0.ND.PA.0.00.FA
Age	\$15000	\$20000	
18-29	\$4.90	\$6.23	
30-39	\$5.66	\$7.24	
40-49	\$10.82	\$14.12	
50-59	\$21.31	\$28.10	
60-64	\$40.00	\$53.03	
65+	\$44.29	\$58.75	
1 Parent Family			
18-29	\$5.14	\$6.49	
30-39	\$5.90	\$7.51	
40-49	\$11.06	\$14.38	
50-59	\$21.55	\$28.37	
60-64	\$40.24	\$53.29	
65+	\$44.53	\$59.01	
2 Parent Family			
18-29	\$6.57	\$8.25	
30-39	\$7.40	\$9.35	
40-49	\$15.81	\$20.57	
50-59	\$31.77	\$41.85	
60-64	\$59.53	\$78.86	
65+	\$65.73	\$87.12	

Issue State: Pennsylvania
Rate generation date: January 25, 2018

**HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.*

Summary of Benefits

Critical Illness Benefit

Critical illness insurance provides a lump-sum cash benefit which the employee can use however they wish. After the critical illness diagnosis, the insured person will receive a lump-sum percentage of the elected benefit amount. The diagnosis must be made after the effective date of the certificate. Percentages for each covered critical illness are shown in the Product Details section of the proposal.

For example, if an employee purchased a benefit amount of \$30,000 and is diagnosed with a heart attack after the effective date, the employee will receive 100 percent of their benefit - a lump sum of \$30,000.

For a different and subsequent critical illness, the insured person will receive an additional lump-sum benefit as long as the diagnosis is made 90 days or more after the last critical illness for which a benefit was paid. If the last critical illness benefit payment under this certificate was less than 100 percent of the applicable benefit amount, we will waive the requirements that the newly diagnosed illness must be medically unrelated and separated by 90 days.

Recurrent Critical Illness Benefit (*Rider Form Series CRRCI500*)

This benefit provides each insured person with an opportunity to receive an additional payment for the same critical illness. The Recurrence Benefit is a percentage of the Critical Illness Benefit amount and the percentage is selected by the employer. A recurrence of the same critical illness must be separated by a 180 day waiting period. For a cancer condition, the insured person must be treatment free for 180 days. Only one Recurrence Benefit will be paid for each critical illness.

If the same employee in the earlier example also had the Recurrent Critical Illness Benefit Rider and undergoes another heart attack two years later, the employee would receive a percentage of their benefit elected by their employer. If their employer chose a 50 percent recurrent critical illness benefit, the employee would receive 50 percent of their \$30,000 benefit amount - \$15,000.

Wellness Indemnity Benefit Rider (*Rider Form Series CRWEL500*)

Transamerica is committed to providing support for out of pocket expenses associated with health screening tests. This benefit can help pay the costs for a screening test for early disease signs and lead to earlier intervention, better outcomes and healthier employees. The benefit is payable once per calendar year per insured person for one of the following health screening tests:

Biopsy	Chest x-ray	Pap test
Blood test for triglycerides	Colonoscopy	PSA (prostate-specific antigen tests)
Bone marrow testing	Fasting blood glucose test	Serum cholesterol test to determine HDL/LDL level
Breast ultrasound	Flexible sigmoidoscopy	Serum protein electrophoresis (blood test for myeloma)
CA 125 (blood test for ovarian cancer)	Hemoccult stool specimen	Stress test on a bicycle or treadmill
CA 15-3 (blood test for breast cancer)	Mammogram	Thermography
CEA (blood test for colon cancer)		

Critical illness definitions

Critical illness - One of the illnesses or conditions listed below positively diagnosed by a physician. It must be based on diagnostic criteria generally accepted by the medical profession, as defined below.

Alzheimer's disease - A clinically established disease diagnosed by a psychiatrist or neurologist which results in the inability to independently perform two or more daily living activities such as bathing, dressing, eating, toileting, transferring or continence.

Coronary artery disease requiring bypass grafts - Coronary artery disease requiring a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts, as confirmed in writing by a board-certified cardiologist. Angiographic evidence to support the necessity for this surgery will be required. For purposes of this benefit, a surgical operation to correct narrowing or blockage does not include the following procedures: balloon angioplasty, laser embolectomy, atherectomy, stent placement or other non-surgical procedures.

Coronary artery disease requiring angioplasty/stent - Coronary artery disease requiring a balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries, as confirmed in writing by a board-certified cardiologist. This benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries or other peripheral arteries is not coronary artery disease and does not qualify for this benefit.

End stage renal failure - The end stage failure which presents a chronic irreversible failure of both kidneys, and requires treatment by renal dialysis.

Heart attack - The ischemic death of a portion of heart muscle resulting from one or more obstructions of coronary arteries. A positive diagnosis must be supported by either of the following criteria:

1. The presence of three or more of the following indicators:
 - pain, pressure, fullness, discomfort or squeezing in the center of the chest.
 - radiating pain to shoulder(s), neck, back, arm(s) or jaw.
 - new EKG changes indicative of myocardial infarction.
 - diagnostic increase of specific cardiac markers typical for heart attack.
 - confirmed image studies.
2. In the event of death, an autopsy confirmation identifying heart attack as the cause of death.

Summary of Benefits

Major organ failure - The irreversible failure of a heart, lung, pancreas, entire kidney or any combination that a physician determined there is medical evidence to support the complete replacement of such organ with an entire organ from a human donor. It can also be the irreversible failure of an insured person's liver for which a physician has determined that there is medical evidence to support the complete or partial replacement of the liver or liver tissue from a human donor. The transplant need must be due to severe disease.

Miscellaneous diseases - The following diseases will be considered critical illnesses when diagnosed by a physician: amyotrophic lateral sclerosis (Lou Gehrig's disease), encephalitis/meningitis, rocky mountain spotted fever, typhoid fever, anthrax, cholera, primary sclerosing cholangitis (Walter Payton's disease) or tuberculosis.

Other specified organ failure - One of the following occurring independently of any other covered critical illness:

- Loss of sight - the total and irreversible loss of all sight in both eyes.
- Loss of speech - the total and permanent loss of the ability to speak.
- Loss of hearing - the total and irreversible loss of hearing in both ears. Hearing loss that can be corrected by using any hearing aid or device will not be considered an irreversible loss.

Stroke - A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolization of brain tissue from an extracranial source. The diagnosis must be based on:

- Documented neurological deficits; and
- Confirmatory neuroimaging studies.

Stroke does not include cerebral symptoms due to:

- Transient ischemic attack (TIA).
- Reversible neurological deficit.
- Migraine.
- Cerebral injury resulting from trauma or hypoxia.
- Vascular disease affecting the eye, optic nerve or vestibular functions.

Invasive cancer - Cancer evidenced by a malignant tumor and tissue invasion. Invasive cancer does not include pre-malignant conditions or conditions with malignant potential, prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification), and any malignancy associated with the diagnosis of HIV.

Carcinoma in situ - Cancer that stays in its original location, confined to the site without having invaded neighboring tissue.

Prostate cancer with TNM classification of T1 - Microscopic prostate tumors that are neither palpable nor visible on transrectal ultrasonography.

Skin cancer - Basal cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides, which are not considered skin cancers.

Limitations and Exclusions

We do not pay benefits for losses caused by, or as a result of, the insured person's:

- Commission of or attempt to commit a felony or being engaged in an illegal occupation.
- Intentionally causing self-inflicted injury.
- Committing or attempting to commit suicide.
- Membership in the armed forces of any nation, or losses sustained as a result of war or act of war whether declared or undeclared.

Under no condition will we pay any benefits for losses incurred prior to the effective date.

Portability option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us at our administrative office within 31 days after termination. We will bill the employee directly once we receive notification to continue this insurance.

Termination of insurance

Employee insurance will terminate on the earliest of:

- The date the group master policy terminates, subject to the portability option.
- The date an employee ceases to be eligible for insurance.
- The date of the employee's death.
- The premium due date on which we fail to receive the employee's premium.
- The date the employee sends us a written notice to cancel insurance.

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates.
- The premium due date on which we fail to receive the employee's premium.
- The date the dependent no longer meets the definition of dependent.
- The date the group master policy or certificate is modified to exclude dependent insurance.
- The date the employee sends us a written notice to cancel dependent insurance.

We may end the insurance of any insured person who submits a fraudulent claim under the policy. Termination of the employee's insurance will not affect any claim which begins before the date of termination.

Termination of the group master policy

The group may end the policy on any premium due date by submitting a 60-day advance written notice. A group policy will not continue if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the portability option.

Other insurance with us

An employee can only have one critical illness policy or certificate with us. If a person already has critical illness insurance with us, such person is not eligible to apply for this insurance.



Group Name Goes Here.

Underwritten by Transamerica Life Insurance Company

Customer Service: 1-888-763-7474 or www.tebcs.com



Everyone deserves a better Tomorrow. Hospital Select® II is hospital indemnity insurance

When Talia comes down with a particularly nasty cough, what she thought was just a cold soon turns into pneumonia that puts her in the hospital. She and her family are relieved that she responds well to treatment and is discharged within a few days without lasting effects.

Her finances would not recover nearly so easily if she hadn't signed up for her employer's hospital indemnity insurance. With benefits that help complement her major medical insurance, her family is able to overcome financial repercussions after her body overcomes the infection.

Choose flexible benefits to manage health care expenses.

Hospital indemnity insurance pays an amount for each day the insured is hospitalized, up to specific maximum limits. Because the benefits are paid to the insured directly, Talia can use them to help pay for her out-of-pocket expenses, such as her \$1,500 deductible and copays, as well as costs that would be hard to pay due to the work she missed, like her car payment, rent and childcare.

Hospital Select® II features:

- benefits for full-time, part-time, hourly, seasonal and temporary workers (as well as eligible family members)
- no coinsurance, co-pays, waiting periods or deductibles
- benefits paid in addition to other insurance the insured may have
- portability that allows employees to keep insurance after they retire or leave the job

Qualify easily with broad eligibility.

This policy is available for individuals, single-parent families, individuals with spouses or another adult dependent and families. There is no maximum issue age for employees and their adult dependents including common-law marriage partners, domestic partners or civil union partners. Children under the age of 26 can be insured.

THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.

This is a brief summary of Hospital Select® II Limited Group Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPGH1400 AND CCGH1400. Forms and form numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy and riders for complete details.

Product Highlights
No lifetime maximum
No waiting period
Benefits paid directly to you
Payroll-deducted premiums
Family options available

Product Details

The following benefits are included in your plan option(s). Unless otherwise noted, all benefits and maximums are per insured person.

Daily In-Hospital Indemnity Benefit		Plan Option 1
Pays each day an insured person is confined to a hospital (but not an emergency room stay, an outpatient stay, a stay in an observation unit or a recovery room following an outpatient procedure) as the result of a covered accident or sickness.		\$100.00
	Maximum	31 Days per confinement
Intensive Care Indemnity Benefit Rider (Rider Form Series CRCICU00)		
Pays each day an insured person is confined to an intensive care unit as the result of a covered accident or sickness.		\$200.00
	Calendar Year Maximum	30 Days
Hospital Confinement Indemnity Benefit Rider (Rider Form Series CRHA0400)		
Pays each day an insured person is confined to a hospital (but not an emergency room, outpatient stay or stay in an Observation unit) as the result of a covered accident or sickness lasting a minimum of 24 continuous hours from time of admission.		\$750.00
	Maximum	1 day per confinement/1 day(s) per calendar year
Inpatient Miscellaneous Indemnity Benefit Rider (Rider Form Series CRIPM400)		
Pays each day an insured person is confined to a hospital as the result of a covered accident or sickness.		\$50.00
	Maximum	31 days per confinement

Product Details

Plan Option 1 Weekly Rates Hospital Select® II

Ver 1.L3.00.0.00L3.0.00

Age	Employee	Employee and Spouse	Employee and Child(ren)	Family
All Ages	\$4.82	\$10.33	\$7.12	\$11.71

*The illustrated rates DO contain a pre-existing condition limitation.

The above rates are quoted for this group with 50 eligible lives.
Should this plan design sell and the submitted group size is different, rates may be different.

**HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.*

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM EESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES.

Issue State: Pennsylvania
Rate generation date: December 4, 2017

Limitations and Exclusions

Hospital Select® II

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 30 days will be treated as a new and separate confinement.

No benefits under this contract will be payable as the result of the following:

- suicide or attempted suicide.
- intentionally self-inflicted injury.
- immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless Health Screening Indemnity Benefit Rider is included).
- routine physical examinations, including routine newborn care (unless Health Screening Indemnity Benefit Rider is included).
- hospital confinement of a newborn child following the child's birth, unless the newborn child is being treated for accidental injury or sickness.
- being treated for Accidental Injury or Sickness.
- an insured person's abortion, except for medically necessary abortions performed to save the mother's life.
- treatment of mental or emotional disorder.
- treatment of alcoholism or drug addiction.
- an insured person's commission of or attempt to commit a felony, or engagement in an illegal occupation.
- dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- sex change unless medically necessary, reversal of tubal ligation or reversal of vasectomy. Medically necessary covered services will be available to policyholder regardless of their gender identity and medical necessity must be determined by the insured's physician based on the most recent, published medical standards set forth by nationally recognized experts in the transgender health field.
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician's services, unless required by law.
- committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
- traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger or a commercial airline on a regularly scheduled passenger trip.
- an accident or sickness covered by Workers Compensation Act or Occupational Disease Law or by the United States Longshoresman's Harbor Workers Compensation Act.
- an insured person's being on active duty as a member of the armed forces of any nation, or losses sustained as a result of war or act of war whether declared undeclared.

Pre-Existing Condition Limitations

The policy will not pay benefits during the first 12 months the insurance is in force when the accident or illness is due to a pre-existing condition. After that time, loss due to that pre-existing condition will be payable unless it is excluded from coverage.

A pre-existing condition is a Covered Person's disease or physical condition for which medical advice or treatment has been made within 90 days immediately prior to becoming covered under the group Policy.

Portability Option

If the employee loses eligibility for any reason other than nonpayment of premiums, insurance can be continued by paying premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Limitations and Exclusions

Termination of Insurance

The insurance terminates on the earliest of:

- the insured's death.
- the premium due date when we fail to receive a premium, subject to the grace period.
- the date of written notice to cancel insurance.
- the date the policy terminates.
- the date the insured ceases to be eligible for insurance.

Dependent insurance ends on the earliest of:

- the date the insured's insurance terminates for any of the reasons above.
- the date the dependent no longer meets the definition of a dependent.
- the premium due date when we fail to receive a premium, subject to the grace period.
- the date of written notice to cancel insurance.
- the date the policy is modified so as to exclude dependent insurance.

The insurance company has the right to terminate the insurance of any insured who submits a fraudulent claim. Termination will not impact any claim which begins before the date of termination.

Hospital Confinement Indemnity Benefit Rider:

We will not pay benefits under this rider for an emergency room stay, an outpatient stay or a stay in an observation unit or recovery room. We also will not pay a hospital confinement benefit for a newborn child's stay in the hospital unless the newborn child is confined to the hospital and is being treated for an accidental injury or sickness.



1901 Market Street
Philadelphia, PA 19103-1480

INSIGHT PA CYBER CHARTER SCHOOL
350 EAGLEVIEW BLVD
SUITE 350
EXTON, PA 19341

March 26, 2019

Dear Benefit Administrator:

Enclosed is the contract for your 2019 Independence Blue Cross (IBC) health coverage. The contract outlines the benefits available to your group with your IBC plan.

Thank you for choosing IBC for your health coverage needs. If you have any questions about your contract, please contact your broker or IBC Account Executive.

Sincerely,

Paula Sunshine
SVP and Chief Marketing Executive

Enc.

PERSONAL CHOICE HEALTH BENEFITS PROGRAM
A COMPREHENSIVE MAJOR MEDICAL GROUP CONTRACT

By and Between

QCC Insurance Company
(Called "the Health Benefit Plan")
A Pennsylvania Corporation

Located at
1901 Market Street
Philadelphia, PA 19103

And

Group Name: INSIGHT PA CYBER CHARTER SCHOOL

Group Contract Number(s): 10449420

In consideration of the Group's application for coverage and the payment of premiums when due and subject to all terms of this Personal Choice Health Benefits Program Group Contract (the Contract), the Health Benefit Plan hereby agrees to provide each eligible Member of the Group and each eligible Member of the Group's subsidiary or affiliated units, if any, under the above Group Number(s), the benefits as described in The Personal Choice Health Benefits Program Benefit Booklet for eligible persons who enroll hereunder, in accordance with the terms, conditions, limitations, and exclusions of this Contract.

All of the provisions of the Benefit Booklet(s) and all modifications made to such Benefit Booklet(s), attached to and made a part of the Contract, apply to the Contract as if fully set forth in the Contract.

The Group may accept this Contract by making required payments to the Health Benefit Plan. Such acceptance renders all terms and provisions hereof binding on the Health Benefit Plan and the Group.



Paula Sunshine
SVP and Chief Marketing Executive

A Comprehensive Major Medical Contract that utilizes a "Preferred" (In-Network) Provider Network to maximize benefits while offering Members the choice of selecting Out-of-Network Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This Contract utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties.

CONTRACT TABLE OF CONTENTS

CONTRACT DEFINITIONS5
CONTRACT PROVISIONS.....6
SCHEDULE OF BENEFIT BOOKLET(S) 15
CONTRACT RATES 16
GROUP APPLICATION 17
BENEFIT BOOKLET(S)Attached
 SCHEDULE OF COVERED SERVICESAttached

CONTRACT DEFINITIONS

AMENDMENT – A modification to this Contract or Benefit Booklet(s), which changes the original terms of this Contract or Covered Services of the Benefit Booklet(s). The changes contained in the Amendment can take the form of one of the following:

- A. A statutory Amendment, which reflects a change that has been automatically made to satisfy a requirement(s) of any state law, federal law or regulation that would apply to this Contract, as provided in the "Compliance With Law" subsection of the ***Contract Provisions*** section;
- B. A health care Amendment, which reflects a change in the Group's benefits where:
 - 1. The benefits are for services and supplies provided through the Health Benefit Plan's Providers; and
 - 2. The change applies to all group contracts which include these benefits.

When this Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the health care Amendment;

- C. A universal Amendment, which reflects a change in the Health Benefit Plan's administration of its group benefits and is intended to apply to all group contracts which are affected by the change.

When the Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the universal Amendment, unless the Group has rejected the Amendment, in writing, prior to its effective date; or

- D. Any combination of the Amendments shown above.

APPLICANT – An employee who applies for coverage under this Contract which the Health Benefit Plan has entered into with the Group.

APPLICATION AND APPLICATION CARD – The request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Health Benefit Plan, whether such request was made under a prior carrier's contract which is superseded by this Contract, or under this Contract.

EFFECTIVE DATE – 12:01 A.M. on the date, specified in the Group Application of this Contract, on which coverage under this Contract commences for the Group.

GROUP (CONTRACTHOLDER) – Any entity which employs or represents enrolled employees and, as agent for such enrolled employees, is acceptable to the Health Benefit Plan and has agreed to remit premium to the Health Benefit Plan on behalf of enrolled employees and to receive any information from the Health Benefit Plan on behalf of enrolled employees.

CONTRACT PROVISIONS

A. ENTIRE CONTRACT; CHANGES

1. The entire Contract consists of:
 - a. The Benefit Booklet(s) attached to this Contract;
 - b. Any Amendment made to this Contract or Benefit Booklet(s);
 - c. Individual applications, if any, of the persons covered; and
 - d. The forms shown in ***Contract Table of Contents***, as of the Effective Date of the Contract between the Group and the Health Benefit Plan.

No change in this Contract will be effective until approved by an authorized officer of the Health Benefit Plan. This approval must be noted on or attached to this Contract via an Amendment, signed by an officer of the Health Benefit Plan. No agent or representative of the Health Benefit Plan, other than an officer of the Health Benefit Plan may otherwise change this Contract or waive any of its provisions.

Fraudulent Statements

All statements made by the Group or by any individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to claim under this Contract, unless it is contained in a written instrument furnished to the Group or a Member.

2. The Group may not transfer enrollment to another type of Contract issued by the Health Benefit Plan until the expiration of a period of one (1) year from the Effective Date of this Contract and thereafter from year to year except as otherwise approved by the Health Benefit Plan.

B. TERMINATION OF THE GROUP CONTRACT

1. The Group may terminate this Contract on any Anniversary Date by giving written notice to the Health Benefit Plan at least thirty (30) days in advance.
2. This Contract will be terminated for the Group's nonpayment of premium, subject to the "Grace Period" subsection of this ***Contract Provisions*** section.
3. The Health Benefit Plan reserves the right to terminate this Contract by giving thirty (30) days notice to the Group, in writing, if the Group fails to meet the Health Benefit Plan's Underwriting Guidelines including, but not limited to, the Group's minimum participation requirements.
4. This Contract will be terminated, at the Health Benefit Plan's option, for fraud or intentional misrepresentation of a material fact by the Group.

5. The Health Benefit Plan may, at its option, amend this Contract at least annually. If the Group does not agree to such change(s), the Group must notify the Health Benefit Plan and the Group may terminate this Contract at the end of the then current contract term.
6. Either the Group or the Health Benefit Plan may at any time cancel this Contract or the Health Benefit Plan may at any time migrate your group coverage under this Contract to another benefit program by giving written notice to the other party at least ninety (90) days in advance.

C. **GRACE PERIOD**

This Contract has a grace period of thirty (30) days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period the Contract will stay in force unless prior to the date payment was due the Group gave timely written notice to the Health Benefit Plan that the Contract is to be cancelled. If the Group does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period. The Group will be required to reimburse the Health Benefit Plan for all outstanding premiums including the premium for the grace period.

D. **APPLICABLE LAW**

This Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

E. **COMPLIANCE WITH LAW**

If the provisions of the Contract do not conform to the requirements of any state law, federal law or regulation that would be applicable to the Contract, the Contract is automatically changed to comply with the Health Benefit Plan's interpretation of the requirements of that law or regulation.

F. **NOTICE**

Any notice required under this Contract must be in writing. Notice given to the Group will be sent to the Group's address stated in the **Group Application**. Notice given to the Health Benefit Plan will be sent to the Health Benefit Plan's address stated in the **Group Application**. Notice given to a Member will be given to the Member in care of the Group or sent to the Member's last address furnished to the Health Benefit Plan by the Group. The Group, the Health Benefit Plan, or a Member may, by written notice, indicate a new address for giving notice.

G. **IDENTIFICATION CARDS**

The Health Benefit Plan will provide Identification Cards to Members or to the Group, depending on the direction of the Group. Any Identification Card issued by the Health Benefit Plan in connection with the coverages provided by this Contract, are for identification only. Possession of the Identification Card does not convey any rights to benefits under this Contract. If any Member permits another person to use the Member's Identification Card, the Health Benefit Plan may revoke that Member's Identification Card.

H. **BENEFIT BOOKLETS**

The Health Benefit Plan will also provide to each Member of an enrolled Group a Benefit Booklet entitled "The Personal Choice Health Benefits Program" or "The Preferred Provider Organization Health Benefit Program". It will describe the Member's coverage under the Contract. It will include:

1. To whom the Health Benefit Plan pays benefits;
2. Any protection or rights when the coverage ends; and
3. Claim rights and requirements.

I. **TIMELY FILING**

1. The Health Benefit Plan will not be liable under this Contract unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within ninety (90) days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.
2. Failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than twelve (12) months after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by In-Network Providers.

J. **RECORDS OF EMPLOYEE ELIGIBILITY AND CHANGES IN EMPLOYEE ELIGIBILITY**

1. The Group must furnish the Health Benefit Plan with any data required by the Health Benefit Plan for coverage of Members under this Contract. In addition, the Group must provide written notification to the Health Benefit Plan within thirty-one (31) days of the effective date of any changes in a Member's coverage status under this Contract.
2. All notification by the Group to the Health Benefit Plan must be furnished on forms approved by the Health Benefit Plan. The notification must include all information required by the Health Benefit Plan to effect changes.
3. Clerical errors or delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate.
4. If Contract benefits are provided by and/or approved by the Health Benefit Plan for Covered Services rendered to a Member before the Health Benefit Plan receives notice of the Member's termination under the Contract, the cost of such benefits will be the sole responsibility of the Member. The effective date of termination of a Member under the Contract shall not be more than thirty (30) days before the first day of the month in which the Group notified the Health Benefit Plan of such termination.

K. RELEASE OF INFORMATION

The Health Benefit Plan may furnish membership and/or coverage information to affiliated plans or other entities for the purpose of claims processing or facilitating patient care.

The Health Benefit Plan reserves the right to obtain personal health information, medical records, and/or authorizations for care and treatment, in order to establish the Medical Necessity of a treatment, procedure, drug or device for purposes of paying benefits under this Contract.

When the Health Benefit Plan needs to obtain consent for the release of personal health information, medical records, and/or authorization of care and treatment, or to have access to information from a Member who is unable to provide it, the Health Benefit Plan will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Member.

L. TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim Incurred commencing after the expiration of such three (3) year period.

M. LIMITATIONS OF THE HEALTH BENEFIT PLAN'S LIABILITY

The Health Benefit Plan shall not be liable for injuries or damage resulting from acts or omissions of any officer or employee of the Health Benefit Plan or of any Provider or other person furnishing services or supplies to the Member; nor shall the Health Benefit Plan be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

N. RIGHT TO RECOVER PAYMENTS IN ERROR

If the Health Benefit Plan should pay for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.

O. RIGHT TO ENFORCE CONTRACT PROVISIONS

If the Health Benefit Plan shall choose to waive their rights under this Contract regarding a specific term or provision, it shall not be interpreted as a waiver of their right to otherwise administer or enforce this Contract in strict accordance with the terms and provisions of this Contract.

P. LEGAL ACTIONS

No action at law or in equity may be taken to recover benefits prior to the expiration of sixty (60) days after written proof of loss has been given in accordance with the requirements of this Contract, and no such action may be taken later than three (3) years after the date written proof of loss is required to be furnished.

Q. RELATIONSHIPS AMONG PARTIES AFFECTED BY THE CONTRACT

1. The relationship that exists between the Health Benefit Plan and any Provider, who is a member of the Health Benefit Plan's Personal Choice Network, is that of an independent contractor. No Provider, who is a member of the Health Benefit Plan's Personal Choice Network, is an agent or employee of the Health Benefit Plan. The Health Benefit Plan or any employee of the Health Benefit Plan is not an employee or agent of a Provider, who is a member of the Health Benefit Plan's Provider Network. Each Provider, who is a member of the Health Benefit Plan's Personal Choice Network, will maintain the provider-patient relationship with the Members under the Contract and is solely responsible to Members for services and supplies furnished to Members.
2. Neither the Group nor any Member under the Contract is the agent or representative of the Health Benefit Plan. Neither the Group nor any Member under the Contract will be liable for any acts or omissions:
 - a. Of the Health Benefit Plan, its agents or employees; or
 - b. Of any Provider with which the Health Benefit Plan, its agents or employees make arrangements for furnishing services and supplies to Members.
3. The choice of a Provider is solely the Member's choice.

R. TERMINATION OF IN-NETWORK HOSPITAL OR IN-NETWORK SKILLED NURSING FACILITY CONTRACT

The contract between the Health Benefit Plan and an In-Network Hospital or an In-Network Skilled Nursing Facility may be terminated, without notice to the Member, in accordance with the provisions thereof.

S. BLUECARD PROGRAM

Out-of-Area Services

Overview

QCC Insurance Company ("QCC") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under the rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area QCC serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, Members, when accessing care outside the geographic area QCC serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. QCC remains responsible for fulfilling our contractual obligation to the Group. QCC payment practices in both instances

are described below.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by QCC to provide the specific service or services.

1. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services within the geographic area served by a Host Blue/outside the geographic area QCC serves, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to QCC by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to QCC by the Host Blue may represent one of the following:

- a. An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- b. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- c. An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or refunds received or anticipated to be paid to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by QCC in determining the Group's premiums.

2. Special Cases: Value-Based Programs

BlueCard® Program

QCC has included a factor for bulk distributions from Host Blues in the Group's premium for the Value-Based Programs when applicable under this Contract.

Negotiated Arrangements (For non-BlueCard Programs)

If QCC has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group's Member, QCC will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

3. Nonparticipating Providers Outside QCC's Service Area

a. Member Liability Calculation

When Covered Services are provided outside of QCC's service area by nonparticipating providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment QCC will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

b. Exceptions

In some exception cases, at the Group's direction, QCC may pay claims from nonparticipating healthcare providers outside of QCC's service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by QCC in QCC's sole and absolute discretion or by applicable state law. In other exception cases, at the Group's direction, QCC may pay such claims based on the payment QCC would make if QCC were paying a nonparticipating provider inside of QCC's service area, as described elsewhere in this Contract. This may occur where the Host Blue's corresponding payment would be more than QCC's in-service area nonparticipating provider payment. QCC may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and payment QCC will make for the covered services as set forth in this paragraph.

4. Blue Cross Blue Shield Global Core

• General Information

If Members are outside the United States, the Commonwealth of Puerto Rico and

the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- Inpatient Services

In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their Deductibles, Coinsurance, etc. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact QCC to obtain precertification for non-emergency inpatient services.**

- Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

T. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Group is hereby notified:

This Contract is between the Member or Group, on behalf of itself and Members, and the Health Benefit Plan. The Health Benefit Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows the Health Benefit Plan to use the familiar Blue Cross words and symbols. The Health Benefit Plan, which is entering into this Contract, is not contracting as an agent of the national Association. Only the Health Benefit Plan shall be liable to the Member or Group, on behalf of itself and the Members for any of the Health Benefit Plan's obligations under this Contract. This paragraph does not add any obligations to this Contract.

U. PREMIUM RATES

Premium rates may be changed on the Anniversary Date of the Contract during any year in which the Contract remains in effect, provided that written notice of such proposed change shall be given to the Group by the Health Benefit Plan on its own behalf not later than thirty

(30) days prior to the Anniversary Date of the Contract. Provided, however, that if less than thirty (30) days notice is given by the Health Benefit Plan, the new premium rate will be effective on the first day of the month following the Anniversary Date. It is also agreed that notice of such change to the Group is notice to those Members enrolled hereunder, and that payment of the new charges shall constitute acceptance of the change in premium rates. In addition, the premium rates may be changed at any time upon mutual consent of the parties.

If the Health Benefit Plan determines that a change in the Contract is required by statute or regulation which increases the Health Benefit Plan's risk under this Contract, the Health Benefit Plan may change the premium upon thirty (30) days written notice.

The Health Benefit Plan may from time to time determine to abate (all or some of) the premium due under this Contract for particular period(s).

Any abatement of premium by the Health Benefit Plan represents a determination by the Health Benefit Plan not to collect the premium for the applicable period(s) and does not effect a reduction in the rates under this Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

The Health Benefit Plan may from time to time offer programs such as wellness programs and other incentive or reward programs to the Group and Members enrolled hereunder.

V. **IDENTITY PROTECTION SERVICES**

From time to time, the Health Benefit Plan may offer, provide or arrange for identity protection services to Members enrolled in this Contract. These services may be made available through third parties. The third party service providers are independent contractors and are solely responsible to the Member for the provision of any such services. The Health Benefit Plan reserves the right to modify or discontinue such services at any time.

V. **NON-DISCRIMINATION RIGHTS**

The Member has the right to receive health care services without discrimination:

1. Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
2. For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
3. Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
4. Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

SCHEDULE OF BENEFIT BOOKLET(S)

Subject to the exclusions, conditions and limitations set forth in the attached Benefit Booklet(s), a Member is entitled to benefits for Covered Services when: (a) deemed Medically Necessary; and (b) billed for by a Provider. Payment allowances for Covered Services are described in the **Schedule of Covered Services** section of the Benefit Booklet(s); and provisions for reimbursement of services provided by Facility Providers and Professional Providers are included under the **General Information** section.

CONTRACT RATES

<u>Rating</u>	<u>Total</u>
Single	\$492.76
Parent & Child	\$878.59
Parent & Children	\$878.59
Husband & Wife	\$1,133.83
Family	\$1,445.75

GROUP APPLICATION

Application to:

QCC Insurance Company

whose main office address is
1901 Market Street
Philadelphia, PA 19103

By: **INSIGHT PA CYBER CHARTER SCHOOL**

whose main office address is: 350 Eagleview Blvd
suite 350
Exton, PA 19341

For Group Contract Number(s): 10449420; with an

Effective Date of: January 1, 2019; and an Anniversary Date of: December 31, 2019; and will renew for a further period of twelve (12) consecutive months and thereafter, from year to year, unless terminated as provided by this Contract; and for the coverage afforded by this Contract, and the terms of which are hereby approved and accepted by the Group to be executed on the Effective Date shown above.

The Application is made to the Contract and it is agreed that this Application supersedes any previous Application for this Contract. The signature below is evidence of QCC Insurance Company's acceptance of the Group Contractholder's Application on the terms hereof, and constitutes execution of this Group Contract attached hereto on behalf of QCC Insurance Company.

QCC INSURANCE COMPANY



Brian Lobley
President and SVP, Commercial and Consumer Markets

Attest:



Paula Sunshine
SVP and Chief Marketing Executive

Date: March 26, 2019

THE PERSONAL CHOICE HEALTH BENEFITS PROGRAM

A COMPREHENSIVE MAJOR MEDICAL GROUP BENEFIT BOOKLET

By and Between

QCC Insurance Company
(Called "the Health Benefit Plan")
A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

And

Group (Contractholder)
(Called "the Group")

The Health Benefit Plan certifies that the enrolled Employee and the enrolled Employee's eligible Dependents, if any, are entitled to the benefits described in this Benefit Booklet, subject to the eligibility and Effective Date requirements.

This Benefit Booklet replaces any and all Benefit Booklets previously issued to the Member under any group contracts issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contractholder. This Benefit Booklet is a summary of the provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

QCC INSURANCE COMPANY



Brian Loble
President and SVP, Commercial and
Consumer Markets

ATTEST:



Paula Sunshine
SVP and Chief Marketing Executive

Comprehensive Major Medical Coverage that utilizes a "Preferred" (In-Network) Provider Network to maximize benefits while offering Members the choice of selecting Out-of-Network Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This coverage utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties. Failure to obtain Precertification for services provided by a BlueCard Provider (excluding Inpatient Admissions) or an Out-of-Network Provider will result in a 20% reduction in benefits.

(THIS PAGE INTENTIONALLY BLANK)

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi): توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Dii baa akó nínizin: Dii saad bee yánilti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiiik'eh. Hódiilnih koji' 1-800-275-2583.

Urdu: توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Program provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TABLE OF CONTENTS

Introduction	3
Schedule of Covered Services.....	6
Description of Covered Services.....	12
Primary And Preventive Care.....	12
Inpatient Services	15
Inpatient/Outpatient Services	18
Outpatient Services.....	26
Exclusions - What is Not Covered	40
General Information	50
Eligibility, Change and Termination Rules Under the Program.....	50
Coverage Continuation	52
Information About Provider Reimbursement.....	56
Services and Supplies Requiring Precertification	66
Utilization Review Process and Criteria	71
Coordination of Benefits.....	73
Subrogation and Reimbursement Rights	75
Claim Procedures	78
Complaint and Appeal Process.....	80
Important Definitions	82
Important Notices.....	113
Rights and Responsibilities	115
Language and Coverage Changes	116

(THIS PAGE INTENTIONALLY BLANK)

INTRODUCTION

Thank you for joining QCC Insurance Company (the Health Benefit Plan). Our goal is to provide Members with access to quality health care coverage. This Benefit Booklet is a summary of the Members benefits and the procedures required in order to receive the benefits and services to which Members are entitled. Members' specific benefits covered by the Health Benefit Plan are described in the **Description of Covered Services** section of this Benefit Booklet. Benefits, exclusions and limitations appear in the **Exclusions – What Is Not Covered** and the **Schedule of Covered Services** sections of this Benefit Booklet.

Please remember that this Benefit Booklet is a summary of the provisions and benefits provided in the Program selected by the Member's Group. Additional information is contained in the Group Contract available through the Member's Group benefits administrator. The information in this Benefit Booklet is subject to the provisions of the Group Contract. If changes are made to the Members Group's Program, the Member will be notified by the Members Group benefits administrator. Group Contract changes will apply to benefits for services received after the effective date of change.

If changes are made to this Program, the Member will be notified. Changes will apply to benefits for services received on or after the effective date unless otherwise required by applicable law. The effective date is the *later* of:

- The effective date of the change;
- The Members Effective Date of coverage; or
- The Group Contract anniversary date coinciding with or next following that service's effective date.

Please read the Benefit Booklet thoroughly and keep it handy. It will answer most questions regarding the Health Benefit Plan's procedures and services. **If Members have any other questions, they should call the Health Benefit Plan's Customer Service Department ("Customer Service") at the telephone number shown on the Members Identification Card ("ID Card").**

Any rights of a Member to receive benefits under the Group Contract and Benefit Booklet are personal to the Member and may not be assigned in whole or in part to any person, Provider or entity, nor may benefits be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract and Benefit Booklet, as required by law.

See **Important Notices** section for updated language and coverage changes that may affect this Benefit Booklet.

Your Costs		
Benefit Period	Contract Year (12 month period beginning on Group's anniversary date)	
	IN-NETWORK	OUT-OF-NETWORK
Program Deductible		
Individual	\$1,500	\$5,000
Family	\$3,000*	\$10,000*
<p>* In each Benefit Period, it will be applied to all family members covered under a Family Coverage. A Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Deductible, or that covered family member has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.</p>		
	IN-NETWORK	OUT-OF-NETWORK
Coinsurance	0% for Covered Services, except as otherwise specified in the <i>Schedule of Covered Services</i> .	50% for Covered Services, except as otherwise specified in the <i>Schedule of Covered Services</i> .
Out-of-Pocket Limit		
Individual	\$7,350	\$10,000
Family	\$14,700	\$20,000
<p><i>Note for Out-Of-Pocket Limit shown above:</i> When a Member Incurs the level of In-Network Out-of-Pocket expenses listed above of Copayment, Deductible and Coinsurance expense in one Benefit Period for In-Network Covered Services, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that Benefit Period. After the Family In-Network Out-of-Pocket Limit amount has been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that Benefit Period. However, no family member will contribute more than the individual In-Network Out-of-Pocket amount. The amount of the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit will only include expenses for Essential Health Benefits. The In-Network dollar amounts specified shall not include any expense Incurred for any Penalty amount. When a Member Incurs the level of Out-of-Network Out-of-Pocket expenses listed above of Deductible and Coinsurance expense in one Benefit Period for Out-of-Network Covered Services, the Coinsurance percentage will be reduced to 0% and no additional Deductible(s) will be required for the balance of that Benefit Period. After the Family Out-of-Network Out-of-Pocket Limit amount has been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Deductible(s) will be required for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Network Out-of-Pocket amount. The Out-of-Network dollar amounts specified shall not include any expense Incurred for any Deductible, Penalty or Copayment amount.</p>		
Lifetime Maximum	Unlimited	Unlimited

SCHEDULE OF COVERED SERVICES

This **Schedule of Covered Services** is an overview of the benefits you are entitled to. More details can be found in the **Description of Covered Services** section.

Subject to the exclusions, conditions and limitations of this Program, a Member is entitled to benefits for the Covered Services described in this **Schedule of Covered Services** during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. The percentages for Coinsurance and Covered Services shown in this **Schedule of Covered Services** are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the "Covered Expense" definition in the **Important Definitions** section.

Some Covered Services must be Precertified before the Member receives the services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the **General Information** section.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Acupuncture⁽⁴⁾	\$40 Copayment per visit, Deductible does not apply	50%, after Deductible
<i>Note for Acupuncture shown above: Benefit Period Maximum: 18 In-Network/Out-of-Network visits</i>		
Alcohol Or Drug Abuse And Dependency⁽³⁾		
Inpatient Hospital Detoxification and Rehabilitation	None, after Deductible *	50%, after Deductible**
Hospital and Non-Hospital Residential Care	None, after Deductible *	50%, after Deductible**
Outpatient Treatment	\$40 Copayment per visit, Deductible does not apply	50%, after Deductible
<p>* In-Network Benefit Period Maximum: Unlimited Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.</p> <p>** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.</p>		
Ambulance Services⁽⁴⁾		
Emergency Services	0%, after Deductible	0%, after In-Network Deductible
Non-Emergency Services	None, after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorders⁽⁴⁾	Same cost-sharing as any other medical service within the applicable medical service (For example, Therapy Services, Diagnostic Services, etc.)	Same cost-sharing as any other medical service within the applicable medical service (For example, Therapy Services, Diagnostic Services, etc.)
<p><i>Note for Autism Spectrum Disorders shown above:</i></p> <p>Annual Benefit Maximum for non-essential benefits: \$40,501.</p> <p>Benefit Period Maximums and visit limits do not apply</p> <p>If this Program does not provide coverage for prescription drugs, Autism Spectrum Disorders medications are covered less the applicable Coinsurance per 30 day prescription order:</p> <p>Generic Coinsurance – 30% Brand Coinsurance – 30%</p> <p>Deductible does not apply</p>		
Blood⁽³⁾	None, after Deductible	50%, after Deductible
Colorectal Cancer Screening⁽⁴⁾	None, after Deductible	50%, after Deductible
Diabetic Education Program⁽⁴⁾	None, Deductible does not apply	Not Covered
<p><i>Note for Diabetic Education Program shown above: Copayments, Deductibles and Maximum amounts do not apply to this benefit</i></p>		
Diabetic Equipment And Supplies⁽⁴⁾	None, after Deductible	50%, after Deductible
Diagnostic/Radiology Services - Non-Routine⁽⁴⁾ (including MRI/MRA, CT scans, PET scans, Sleep Studies)	\$80 Copayment per date of service, Deductible does not apply	50%, after Deductible
Diagnostic/Radiology Services – Routine⁽⁴⁾	\$40 Copayment per date of service, Deductible does not apply	50%, after Deductible
Durable Medical Equipment And Consumable Medical Supplies⁽⁴⁾	None, after Deductible	50%, after Deductible
Emergency Care Services⁽⁴⁾	\$250 Copayment per visit (not waived if admitted), after Deductible	\$250 Copayment per visit (not waived if admitted), after In-Network Deductible
Home Health Care⁽⁴⁾	None, after Deductible	50%, after Deductible
<p><i>Note for Home Health Care shown above: Benefit Period Maximum: 60 visits</i></p>		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Hospice Services⁽³⁾	None, after Deductible	50%, after Deductible
<i>Note for Hospice Services shown above: Respite Care: Maximum of seven In-Network/Out-of-Network days every six months.</i>		
Hospital Services⁽²⁾		
Facility Charge	None, after Deductible*	50%, after Deductible**
Professional Charge	None, after Deductible	50%, after Deductible
<p>* In-Network Benefit Period Maximum: Unlimited Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.</p> <p>** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.</p>		
Immunizations⁽¹⁾	None, Deductible does not apply	50%, Deductible does not apply
Injectable Medications⁽⁴⁾		
Specialty Drug	\$100 Copayment per injection, Deductible does not apply	50%, after Deductible
Standard Injectable Drugs	None, Deductible does not apply	50%, after Deductible
Insulin and Oral Agents⁽⁴⁾	None, less the Copayment amount, if applicable	None, less the Copayment amount, if applicable
Laboratory and Pathology Tests⁽⁴⁾	\$80 Copayment per date of service, Deductible does not apply	50%, after Deductible
Maternity/OB-GYN/Family Services⁽³⁾		
Artificial Insemination	None, after Deductible	50%, after Deductible
Elective Abortions		
Professional Service	\$20 Copayment per Provider per date of service, Deductible does not apply.	50%, after Deductible
Outpatient Facility Charges	None, after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Maternity/Obstetrical Care		
Professional Service	Single Copayment of \$20, Deductible does not apply.	50%, after Deductible
Facility Service	None, after Deductible	50%, after Deductible
Newborn Care	None, after Deductible	50%, after deductible
Medical Care⁽²⁾	None, after Deductible	50%, after Deductible
Medical Foods and Nutritional Formulas⁽⁴⁾	None	50%, Deductible does not apply
Mental Health/Psychiatric Care ⁽³⁾		
Inpatient	None, after Deductible*	50%, after Deductible**
Outpatient	\$40 Copayment per visit, Deductible does not apply	50%, after Deductible
<p>* In-Network Benefit Period Maximum: Unlimited Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.</p> <p>** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.</p>		
Methadone Treatment⁽⁴⁾	None, Deductible does not apply	50%, after Deductible
Non-Surgical Dental Services⁽⁴⁾	None, after Deductible	50%, after Deductible
<i>Note for Non-Surgical Dental Services shown above: Dental Services as a Result of Accidental Injury</i>		
Nutrition Counseling For Weight Management⁽¹⁾	None, Deductible does not apply	50%, after Deductible
<i>Note for Nutrition Counseling For Weight Management shown above: Benefit Period Maximum: 6 In-Network/Out-of-Network visits</i>		
Orthotics⁽⁴⁾	None, after Deductible	50%, after Deductible
Podiatric Care⁽⁴⁾	\$40 Copayment per visit, Deductible does not apply	50%, after Deductible
Preventive Care – Adult⁽¹⁾	None, Deductible does not apply	50%, Deductible does not apply
Preventive Care – Pediatric⁽¹⁾	None, Deductible does not apply	50%, Deductible does not apply

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Office Visits/Retail Clinics⁽¹⁾	\$20 Copayment per visit, Deductible does not apply	50%, after Deductible
Prosthetic Devices⁽⁴⁾	None, after Deductible	50%, after Deductible
Skilled Nursing Facility Services⁽²⁾	None, after Deductible	50%, after Deductible
<i>Note for Skilled Nursing Facility Services shown above: Benefit Period Maximum: 120 In-Network/Out-of-Network Inpatient days</i>		
Smoking Cessation⁽¹⁾	None, Deductible does not apply.	50%, Deductible does not apply
Specialist Office Visits⁽⁴⁾	\$40 Copayment per visit Deductible does not apply	50%, after Deductible
Spinal Manipulation Services⁽⁴⁾	\$40 Copayment per visit, Deductible does not apply	50%, after Deductible
<i>Note for Spinal Manipulation Services shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network visits.</i>		
Surgical Services⁽³⁾		
Outpatient Ambulatory Surgical Center	None, after Deductible	50%, after Deductible
Outpatient Facility Charge	None, after Deductible	50%, after Deductible
Outpatient Professional Charge	None, after Deductible	50%, after Deductible
Outpatient Anesthesia	None, after Deductible	50%, after Deductible
Second Surgical Opinion	\$40 Copayment per opinion Deductible does not apply	50%, after Deductible
<i>Note for Surgical Services shown above: If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Health Benefit Plan will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.</i>		
Therapy Services⁽⁴⁾		
Cardiac Rehabilitation Therapy	\$40 Copayment per session, Deductible does not apply	50%, after Deductible
<i>Note for Cardiac Rehabilitation Therapy shown above: Benefit Period Maximum: 36 In-Network/Out-of-Network sessions.</i>		
Chemotherapy	None, after Deductible	50%, after Deductible
Dialysis	None, after Deductible	50%, after Deductible
Infusion Therapy	None, after Deductible.	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Physical Therapy/Occupational Therapy	\$40 Copayment per session , Deductible does not apply	50%, after Deductible
<i>Note for Physical Therapy/Occupational Therapy shown above: Benefit Period Maximum: 30 in Network/Out of Network sessions of Physical Therapy/Occupational Therapy combined.</i> Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.		
Pulmonary Rehabilitation Therapy	\$40 Copayment per session , Deductible does not apply	50%, after Deductible
<i>Note for Pulmonary Rehabilitation Therapy shown above: Benefit Period Maximum: 36 In-Network/Out-of-Network sessions.</i>		
Radiation Therapy	None, after Deductible	50%, after Deductible
Respiratory Therapy	\$40 Copayment per session, Deductible does not apply	50%, after Deductible
Speech Therapy	\$40 Copayment per session, Deductible does not apply	50%, after Deductible
<i>Note for Speech Therapy shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network sessions.</i>		
Transplant Services⁽³⁾		
Inpatient Facility Charge	None, after Deductible	50%, after Deductible
Outpatient Facility Charge	None, after Deductible	50%, after Deductible
Urgent Care Centers⁽⁴⁾	\$85 Copayment per visit, Deductible does not apply	50%, after Deductible
Women's Preventive Care⁽¹⁾	None, Deductible does not apply.	50%, Deductible does not apply
<i>Note for Women's Preventive Care shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% for generic products and for certain brand products when a generic alternative or equivalent to the brand product does not exist. All other Brand contraceptive products are not covered.</i>		

BENEFIT	If the Member utilizes MDLIVE	If the Member does not utilize MDLIVE
Telemedicine Services⁽⁴⁾ Provided by MDLIVE	None, Deductible does not apply	Not Covered

- (1) Located in the Primary & Preventive Care Section of the ***Description of Covered Services***
- (2) Located in the Inpatient Section of the ***Description of Covered Services***
- (3) Located in the Inpatient/Outpatient Section of the ***Description of Covered Services***
- (4) Located in the Outpatient Section of the ***Description of Covered Services***

DESCRIPTION OF COVERED SERVICES

Subject to the exclusions, conditions and limitations of this Program, a Member is entitled to benefits for the Covered Services described in this **Description of Covered Services** section during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. These amounts and percentages, and other cost-sharing requirements are specified in the **Schedule of Covered Services**.

Covered Services may be provided by either an In-Network or Out-of-Network Provider. However, the Member will maximize the benefits available when Covered Services are provided by a Provider that belongs to the Personal Choice Network (an In-Network Provider) and has a contract with the Health Benefit Plan to provide services and supplies to the Member. The Member will be held harmless for Out-of-Network differentials if: an In-Network Provider fails to provide written notice to the Member of the Provider's Out-of-Network status for certain services; or, an In-Network Provider provides a written order for certain services to be performed by an In-Network Provider that has Out-of-Network status for those services and that Provider performs such service. The **General Information** section provides more detail regarding In-Network and Out-of-Network Providers, the Personal Choice Network, and the reimbursement of Covered Services provided by Facility Providers and Professional Providers.

Some Covered Services must be Precertified before the Member receives the services. Precertification of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the **General Information** section.

PRIMARY AND PREVENTIVE CARE

A Member is entitled to benefits for Primary Care and Preventive Care Covered Services when deemed Medically Necessary and billed for by a Provider. Cost-sharing requirements are specified in the **Schedule of Covered Services**.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Member has no symptoms of disease. "Primary Care" services generally describe health care services performed to treat an illness or injury.

The Health Benefit Plan reviews the schedule of Covered Services, at certain times. Reviews are based on recommendations from organizations such as:

- The American Academy of Pediatrics;
- The American College of Physicians;
- The U.S. Preventive Services Task Force; and
- The American Cancer Society.

Accordingly, the frequency and eligibility of Covered Services are subject to change. A list of Preventive Care Covered Services can be found in the Preventive Schedule document. A complete listing of recommendations and guidelines can be found at <https://www.healthcare.gov/preventive-care-benefits/>.

The Health Benefit Plan reserves the right to modify the Preventive Schedule document at any time. However, the Member has to be given a written notice of the change, before the change takes effect.

Immunizations

The Health Benefit Plan will provide coverage for the following:

- Pediatric immunizations;
- Adult immunizations; and
- The agents used for the immunizations.

All immunizations, and the agents used for them, must conform to the standards set by the *Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services.*

Pediatric and adult immunization schedules can be found in the Preventive Schedule document.

The benefits for these pediatric immunizations are limited to Members under 21 years of age.

Nutrition Counseling for Weight Management

The Health Benefit Plan will provide coverage for nutrition counseling visits or sessions for the purpose of weight management. However, they need to be performed and billed by any of the following Providers, in an office setting:

- By the Member's Physician;
- By a Specialist; or
- By a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Benefit Booklet.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

The Health Benefit Plan will provide coverage for Bone Mineral Density Testing (BMDT), in accordance with the Preventive Schedule document. The method used needs to be one that is approved by the U.S. Food and Drug Administration. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which depends on both bone density and bone quality. Bone quality refers to how the bone is built, architecture, turnover and mineralization of bone.

A BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

Preventive Care - Adult

The Health Benefit Plan will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Preventive Care - Pediatric

The Health Benefit Plan will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Primary Care Physician Office Visits/Retail Clinics

The Health Benefit Plan will provide coverage for Medical Care visits, by a Primary Care Provider, for any of the following services:

- The examination of an illness or injury;
- The diagnosis of an illness or injury; and
- The treatment of an illness or injury.

For the purpose of this benefit, "Office Visits" include:

- Medical Care visits to a Provider's office;
- Medical Care visits by a Provider to a Member's residence; or
- Medical Care consultations by a Provider on an Outpatient basis.

In addition to Office Visits a Member may receive Medical Care at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners, who are trained to diagnose, treat, and write prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on-call during clinic hours to provide guidance and direction when necessary.

Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to:

- Sore throat;
- Ear, eye, or sinus infection;
- Allergies;
- Minor burns;
- Skin infections or rashes; and
- Pregnancy testing.

Smoking Cessation

Smoking cessation includes clinical preventive services rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) as described under the Preventive Services provision of the Patient Protection and Affordable Care Act.

Women's Preventive Care

The Health Benefit Plan will provide coverage for an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, and other Covered Services, in accordance with the Preventive Schedule document. Covered Services and Supplies include, but are not limited to, the following:

- Routine Gynecological Exam, Pap Smear: Female Members are covered for one routine gynecological exam each Benefit Period. This includes the following:
 - A pelvic exam and clinical breast exam; and
 - Routine Pap smears.

These must be done in accordance with the recommendations of the *American College of Obstetricians and Gynecologists*.

- Mammograms: Coverage will be provided for screening mammograms. The Health Benefit Plan will only provide coverage for benefits for mammography if the following applies:
 - It is performed by a qualified mammography service provider.
 - That service provider is properly certified by the appropriate state or federal agency.
 - That certification is done in accordance with the Mammography Quality Assurance Act of 1992.
- Breastfeeding comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under Durable Medical Equipment supplier with Medical Necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member when provided by an In-Network Provider.
- Contraception: Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the Member when provided by an In-Network Provider.

If a female Member's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services (based on the women's health status, health needs and other risk factors), the additional visit(s) will be provided without cost-sharing.

INPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient Care are Covered Services when they are:

- Deemed Medically Necessary;
- Provided by a Facility Provider and billed by a Provider; and
- Preapproved by the Health Benefit Plan.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Hospital Services

- Ancillary Services
The Health Benefit Plan will provide coverage for all ancillary services usually provided and billed for by Hospitals, except for personal convenience items. This includes, but is not limited to:
 - Meals, including special meals or dietary services, as required by the Member's condition;
 - Use of operating room, delivery room, recovery room, or other specialty service rooms and any equipment or supplies in those rooms;
 - Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
 - Oxygen and oxygen therapy;
 - Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
 - Therapy Services when administered by a person who is appropriately licensed and authorized to perform such services;
 - All drugs and medications (including intravenous injections and solutions);
 - For use while in the Hospital;
 - Which are released for general use; and
 - Which are commercially available to Hospitals.

- Use of special care units, including, but not limited to intensive care units or coronary care units; and
 - Pre-admission testing.
- **Room and Board**
The Health Benefit Plan will provide coverage for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:
 - An average semi-private room, as designated by the Hospital; or a private room, when designated by the Health Benefit Plan as semi-private for the purposes of this Program in Hospitals having primarily private rooms;
 - A private room, when Medically Necessary;
 - A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
 - A bed in a general ward; and
 - Nursery facilities.

Benefits are provided up to the number of days specified in the ***Schedule of Covered Services***.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, an admission occurring within ten calendar days of discharge date from a previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits:

- The Health Benefit Plan will count the day of the Member's admission; but not the day of the Member's discharge.
- If the Member is admitted and discharged on the same day, it will be counted as one day.

The Health Benefit Plan will only provide coverage for days spent during an uninterrupted stay in a Hospital.

It will not provide coverage for:

- Time spent outside of the Hospital, if the Member interrupts the stay and then stay past midnight on the day the interruption occurs; or
- Time spent in the Hospital after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

Medical Care

The Health Benefit Plan will provide coverage for Medical Care rendered to the Member, in the following way, except as specifically provided.

It is Medical Care that is rendered:

- By a Professional Provider who is in charge of the case;
- While the Member is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and
- For a condition not related to Surgery, pregnancy, radiation therapy or Mental Illness.

Such care includes Inpatient intensive Medical Care rendered to the Member:

- While the Member's condition requires a Professional Provider's constant attendance and treatment; and
- For a prolonged period of time.

- Concurrent Care
The Health Benefit Plan will provide coverage for the following services, while the Member is an Inpatient, when they occur together:
 - Services rendered to the Member by a Professional Provider:
 - Who is not in charge of the case; but
 - Whose particular skills are required for the treatment of complicated conditions.
 - Services rendered to the Member as an Inpatient in a:
 - Hospital;
 - Rehabilitation Hospital; or
 - Skilled Nursing Facility.This does not include:
 - Observation or reassurance of the Member;
 - Standby services;
 - Routine preoperative physical examinations;
 - Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods; or
 - Medical Care required by a Facility Provider's rules and regulations.

- Consultations
The Health Benefit Plan will provide coverage for Consultation services when rendered in both of the following ways:
 - By a Professional Provider, at the request of the attending Professional Provider; and
 - While the Member is an Inpatient in a:
 - Hospital;
 - Rehabilitation Hospital; or
 - Skilled Nursing Facility.

Benefits are limited to one consultation per consultant during any Inpatient confinement.

Consultations do not include staff consultations which are required by the Facility Provider's rules and regulations.

Skilled Nursing Facility Services

The Health Benefit Plan will provide coverage for a Skilled Nursing Facility:

- When Medically Necessary as determined by the Health Benefit Plan.
- Up to the Maximum days specified in the ***Schedule of Covered Services***.

The Member must require treatment:

- By skilled nursing personnel;
- Which can be provided only on an Inpatient basis in a Skilled Nursing Facility.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, an admission

occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits:

- The Health Benefit Plan will count the day of the Member's admission; but not the day of the Member's discharge.
- If the Member is admitted and discharged on the same day, it will be counted as one day.

The Health Benefit Plan will only provide coverage for days spent during an uninterrupted stay in a Skilled Nursing Facility.

It will not provide coverage for:

- Time spent outside of the Skilled Nursing Facility, if the Member interrupts their stay and then stays past midnight on the day the interruption occurs;
- Time spent if the Member remains past midnight of the day on which the interruption occurred; or
- Time spent in the Skilled Nursing Facility after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

INPATIENT/OUTPATIENT SERVICES

The Member is entitled to benefits for Covered Services while the Member is an Inpatient in a Facility Provider or on an Outpatient basis when both of the following happen:

- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Blood

The Health Benefit Plan will provide coverage for the administration of blood and blood processing from donors. In addition, benefits are also provided for:

- Autologous blood drawing, storage or transfusion.
 - This refers to a process that allows the Member to have their own blood drawn and stored for personal use.
 - One example would be self-donation, in advance of planned Surgery.
- Whole blood, blood plasma and blood derivatives:
 - Which are not classified as drugs in the official formularies; and
 - Which have not been replaced by a donor.

Hospice Services

The Health Benefit Plan will provide coverage for palliative and supportive services provided to a terminally ill Member through a Hospice program by a Hospice Provider. This also includes Respite Care.

- Who is eligible: The Member will be eligible for Hospice benefits if both of the following occur:
 - The Member's attending Physician certifies that the Member has a terminal illness, with a medical prognosis of six months or less; and
 - The Member elects to receive care primarily to relieve pain.
- The goal of care and what is included: Hospice Care provides services to make the Member as comfortable and pain-free as possible. This is primarily comfort care, and it includes:
 - Pain relief;
 - Physical care;
 - Counseling; and
 - Other services, that would help the Member cope with a terminal illness, rather than cure it.
- What happens to the treatment of the Member's illness: When the Member elects to receive Hospice Care:
 - Benefits for treatment provided to cure the terminal illness are no longer provided.
 - The Member can also change their mind and elect to *not* receive Hospice Care anymore.
- How long Hospice care continues: Benefits for Covered Hospice Services shall be provided until whichever occurs first:
 - The Member's discharge from Hospice Care; or
 - The Member's death.
- Respite Care for the Caregiver: If the Member were to receive Hospice Care primarily in the home, the Member's primary caregiver may need to be relieved, for a short period. In such a case, the Health Benefit Plan will provide coverage for the Member to receive the same kind of care in the following way:
 - On a short-term basis;
 - As an Inpatient; and
 - In a Medicare certified Skilled Nursing Facility.This can only be arranged when the Hospice considers such care necessary to relieve primary caregivers in the Member's home.

Maternity/OB-GYN/Family Services

- Artificial Insemination
Services performed by a Professional Provider for the promotion of fertilization of a female recipient's own ova (eggs):
 - By the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying:
 - Simple sperm preparation;
 - Sperm washing; and/or
 - Thawing.
- Elective Abortions
The Health Benefit Plan will provide coverage for services provided in a Facility Provider that is a Hospital or Birth Center. It also includes services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member, which is a Covered Expense under this Program.

- Maternity/Obstetrical Care

The Health Benefit Plan will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.

- Pre-notification - The Health Benefit Plan should be notified of the need for maternity care within one month of the first prenatal visit to the Physician or midwife.
- Facility and Professional Services - The Health Benefit Plan will provide coverage for:
 - Facility services: Provided by a Facility Provider that is a Hospital or Birth Center; and
 - Professional services: Performed by a Professional Provider or certified nurse midwife.
- Scope of Care - The Health Benefit Plan will provide coverage for:
 - Prenatal care; and
 - Postnatal care.
- Type of delivery - Maternity care Inpatient benefits will be provided for:
 - 48 hours for vaginal deliveries; and
 - 96 hours for cesarean deliveries.

Except as otherwise approved by the Health Benefit Plan.

- Home Health Care for Early Discharge: In the event of early post-partum discharge from an Inpatient Admission:
 - Benefits are provided for Home Health Care, as provided for in the Home Health Care benefit.

- Newborn Care

- A Member's newborn child will be entitled to benefits provided by this Program:
 - From the date of birth up to a maximum of 31 days.
- Such coverage within the 31 days will include care which is necessary for the treatment of:
 - Medically diagnosed congenital defects;
 - Medically diagnosed birth abnormalities;
 - Medically diagnosed prematurity; and
 - Routine nursery care.
- Coverage for a newborn may be continued beyond 31 days under conditions specified in the **General Information** section of this Benefit Booklet.

Mental Health/Psychiatric Care

The Health Benefit Plan will provide coverage for the treatment of Mental Illness and Serious Mental Illness based on the services provided and reported by the Provider. Upon request, the Health Benefit Plan will make available the criteria for Medical Necessity determinations made under the Program for Mental Health/Psychiatric Care to any current or potential Member, Dependent or In-Network Provider.

- Regarding the provision of care other than Mental Health/Psychiatric Care: When a Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Member with Mental Illness and Serious Mental Illness, payment for such Medical Care:
 - Will be based on the Medical Benefits available; and
 - Will not be subject to the Mental Health/Psychiatric Care limitations. Emergency Care will be considered In-Network Care.

- Inpatient Treatment

The Health Benefit Plan will provide coverage, subject to the Benefit Period limitation(s) stated in the **Schedule of Covered Services**, during an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be received from an In-Network Facility Provider and Inpatient visits for the treatment of Mental Illness and Serious Mental Illness must be performed by an In-Network Professional Provider.

Covered Services include treatments such as:

- Psychiatric visits;
- Psychiatric consultations;
- Individual and group psychotherapy;
- Electroconvulsive therapy;
- Psychological testing; and
- Psychopharmacologic management.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the **Schedule of Covered Services**. For purposes of calculating the total Copayment due, an admission occurring within ten calendar days of discharge date from a previous admission shall be treated as part of the previous admission.

- Outpatient Treatment

The Health Benefit Plan will provide coverage for Outpatient treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be performed by an In-Network Professional Provider/In-Network Facility Provider.

Covered Services include treatments such as:

- Psychiatric visits;
- Psychiatric consultations;
- Individual and group psychotherapy;
- Licensed Clinical Social Worker visits;
- Masters Prepared Therapist visits;
- Tele-Behavioral Health services;
- Electroconvulsive therapy;
- Psychological testing;
- Psychopharmacologic management; and
- Psychoanalysis.

- Benefit Period Maximums for Mental Health/Psychiatric Care

All Inpatient Mental Health/Psychiatric Care for both Mental Illness and Serious Mental Illness are covered up to the Maximum day amount(s) per Benefit Period specified in the **Schedule of Covered Services**. Out-of-Network Benefit Period maximums are part of, not separate from, In-Network Benefit Period maximums.

Routine Patient Costs Associated With Qualifying Clinical Trials

- The Health Benefit Plan provides coverage for Routine Patient Costs Associated with Participation in a Qualifying Clinical Trial (see the **Important Definitions** section).
- To ensure coverage and appropriate claims processing, the Health Benefit Plan must be notified in advance of the Member's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by an In-Network Professional Provider, and conducted in an In-Network Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by an In-Network Professional Provider, and in an In-Network Facility Provider, then the Health Benefit Plan will consider the services by an Out-of-

Network Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see **Important Definitions** section) by the Health Benefit Plan.

Surgical Services

The Health Benefit Plan will provide coverage for surgical services provided:

- By a Professional Provider, and/or a Facility Provider
- For the treatment of disease or injury.

Separate payment will not be made for:

- Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure.

Covered Services also include:

- Congenital Cleft Palate - The orthodontic treatment of congenital cleft palates:
 - That involve the maxillary arch (the part of the upper jaw that holds the teeth);
 - That is performed together with bone graft Surgery; and
 - That is performed to correct bony deficits that are present with extremely wide clefts affecting the alveolus.
- Mastectomy Care - The Health Benefit Plan will provide coverage for the following when performed after a mastectomy:
 - All stages of reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prosthesis and physical complications all stages of mastectomy, including lymphedemas; and
 - Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to:
 - Augmentation;
 - Mammoplasty;
 - Reduction mammoplasty; and
 - Mastopexy.
- Coverage is also provided for:
 - The surgical procedure performed in connection with the initial and subsequent insertion or removal of Prosthetic Devices (either before or after Surgery) to replace the removed breast or portions of it;
 - The treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedemas is not subject to any benefit Maximum amounts that may apply to "Physical Therapy" services as provided under the subsection entitled "Therapy Services" of this section; and
 - Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

▪ Anesthesia

- The Health Benefit Plan will provide coverage for the administration of Anesthesia:
 - In connection with the performance of Covered Services;
 - When rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider (except an Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered under this Benefit Booklet).
- General Anesthesia, along with hospitalization and all related medical expenses normally incurred as a result of the administration of general Anesthesia, when rendered in conjunction with dental care provided to Members age seven or under and for developmentally disabled Members when determined by the Health Benefit Plan to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

▪ Assistant at Surgery

The Health Benefit Plan will provide coverage for an assistant surgeon's services if:

- The assistant surgeon actively assists the operating surgeon in the performance of covered Surgery;
- An intern, resident, or house staff member is not available; and
- The Member's condition or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Health Benefit Plan.

Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

▪ Hospital Admission for Dental Procedures or Dental Surgery

The Health Benefit Plan will provide coverage for a Hospital admission in connection with dental procedures or Surgery only when:

- The Member has an existing non-dental physical disorder or condition; and
- Hospitalization is Medically Necessary to ensure the Member's health.

Dental procedures or Surgery performed during such a confinement will only be covered for the services described in "Oral Surgery" and "Assistant at Surgery" provisions.

▪ Oral Surgery

The Health Benefit Plan will provide coverage for Covered Services provided by a Professional Provider and/or Facility Provider for:

- Orthognathic Surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
 - For accidents: The initial treatment of Accidental Injury/trauma (That is, fractured facial bones and fractured jaws), in order to restore proper function.
 - For congenital defects: In cases where it is documented that a severe congenital defect (That is, cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
 - For chewing and breathing problems: In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing.
- Other Oral Surgery - Defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered Service will only be provided for:

- Surgical removal of impacted teeth which are partially or completely covered by bone;
- Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
- Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.

To the extent that the Member has available dental coverage, the Health Benefit Plan reserves the right to seek recovery from the Provider.

The Health Benefit Plan has the right to decide which facts are needed. The Health Benefit Plan may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Health Benefit Plan deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Health Benefit Plan such information as may be necessary to implement this provision.

- Second Surgical Opinion (Voluntary)
The Health Benefit Plan will provide coverage for consultations for Surgery to determine the Medical Necessity of an elective surgical procedure.
 - "Elective Surgery" is that Surgery which is not of an Emergency or life threatening nature;
 - Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

Transplant Services

When a Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants, which are beyond the Experimental/Investigative stage. Benefits, are also provided for those services to the Member which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Member:

- When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under this Program. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the Health Benefit Plan or any government program. When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under this Program.
- When only the donor is a Member, the donor is entitled to the benefits of this Program for all related donor expenses, subject to the following additional limitations:
 - The benefits are limited to only those benefits not provided or available to the donor from any other source for funding or coverage in accordance with the terms of this Program;
 - and
 - No benefits will be provided to the donor recipient.
- If any organ or tissue is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ or tissue.

Treatment for Alcohol or Drug Abuse and Dependency

- Alcohol Or Drug Abuse And Dependency is a disease that can be described as follows: It is an addiction to alcohol and/or drugs. It is also the compulsive behavior that results from this addiction.
 - This addiction makes it hard for a person to function well with other people.
 - It makes it hard for a person to function well in the work that they do.
 - It will also cause person's body and mind to become quite ill if the alcohol and/or drugs are taken away.
- The Health Benefit Plan will provide coverage for the care and treatment of Alcohol Or Drug Abuse And Dependency:
 - Provided by a licensed Hospital or licensed Facility Provider or an appropriately licensed behavioral health Provider.
 - Subject to the Maximum(s) shown in the **Schedule of Covered Services**; and
 - According to the provisions outlined below.
- For maximum benefits, treatment must be received from an In-Network Provider.
- To Access Treatment for Alcohol Or Drug Abuse And Dependency:
 - Call the behavioral health management company at the phone number shown on the Members ID Card.

Upon request, the Health Benefit Plan will make available the criteria for Medical Necessity determinations made under the Program for Alcohol Or Drug Abuse And Dependency to any current or potential Member, Dependent or In-Network Provider.

▪ Inpatient Treatment

- Inpatient Detoxification
Covered Services include:
 - Lodging and dietary services;
 - Physician, Psychologist, nurse, certified addictions counselor, Master's Prepared Therapists, and trained staff services;
 - Diagnostic x-rays;
 - Psychiatric, psychological and medical laboratory testing; and
 - Drugs, medicines, use of equipment and supplies.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the **Schedule of Covered Services**. For purposes of calculating the total Copayment due, any admission occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

- Hospital and Non-Hospital Residential Treatment
Hospital or Non-Hospital Residential Treatment of Alcohol Or Drug Abuse And Dependency shall be covered on the same basis as any other illness covered under this Program.

Covered services include:

- Lodging and dietary services;
- Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing; and
- Drugs, medicines, use of equipment and supplies.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the **Schedule of Covered Services**. For purposes of calculating the total Copayment due, any admission occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

▪ **Outpatient Treatment**

– Covered services include:

- Diagnosis and treatment of substance abuse, including Outpatient Detoxification by the appropriately licensed behavioral health Provider;
- Appropriately licensed behavioral health providers including Physician, Psychologist, nurse, certified addictions counselor, Master's Prepared Therapists, and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing; and
- Medication management and use of equipment and supplies.

OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Outpatient Care are Covered Services when:

- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the **Schedule of Covered Services** section to find how much of those or other costs the Member is required to share (pay).

Acupuncture

The Health Benefit Plan will provide coverage for Acupuncture up to the limits specified in the **Schedule of Covered Services** for all Covered Services.

Ambulance Services

The Health Benefit Plan will provide coverage for ambulance services. However, these services need to be:

- Medically Necessary as determined by the Health Benefit Plan; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when the following applies;
 - The vehicle is licensed as an ambulance, where required by applicable law;
 - The ambulance transport is appropriate for the Member's clinical condition;
 - The use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would endanger the Member's health or be inappropriate for the Member's medical condition; and

- The ambulance transport satisfies the destination and other requirements as stated under Regarding Emergency Ambulance transport or Regarding Non-Emergency Ambulance transports.

Benefits are payable for air or sea ambulance transportation only if the Member's condition, and the distance to the nearest facility able to treat the Member's condition, justify the use of an alternative to land transport.

- Regarding Emergency Ambulance transport: The ambulance must be transporting the Member:
 - From the Member's home, or the scene of an accident or Medical Emergency;
 - To the nearest Hospital, or other Emergency Care Facility, that can provide the Medically Necessary Covered Services for the Member's condition.
- Regarding Non-Emergency Ambulance transports: Non-Emergency air or ground facility transport may be covered when Medically Necessary as determined by the Health Benefit Plan (For example, sending facility does not have the required services to effectively treat the Member, such as trauma or burn care). Non-Emergency air or ground transport may be covered to transport the Member back to an In-Network Facility Provider as determined by the Health Benefit Plan, when:
 - The transfer is Medically Necessary (as determined by the Health Benefit Plan's definition of Medical Necessity); and
 - The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance.

Non-Emergency ambulance transports are not provided for family members or companions or for the convenience of the Member, the family, or the Provider treating the Member.

Autism Spectrum Disorders (ASD)

The Health Benefit Plan will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Members under 21 years of age subject to the Annual Benefit Maximum specified in the ***Schedule of Covered Services***.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician assistant, licensed Psychologist or Certified Registered Nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than 12 months, unless a licensed Physician or licensed Psychologist determines an earlier assessment is necessary.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is:

- Prescribed, ordered or provided by a licensed Physician, licensed Physician assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;
- Provided by an Autism Service Provider, including a Behavior Specialist; or
- Provided by a person, entity or group that works under the direction of an Autism Service Provider.

An ASD Treatment Plan shall be developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The ASD Treatment Plan may be reviewed by the Health Benefit Plan once every six months. A more or less frequent review can be agreed upon by the Health Benefit Plan and the licensed Physician or licensed Psychologist developing the ASD Treatment Plan.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed Physician or licensed Psychologist:

- Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- Pharmacy Care - Medications prescribed by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner to determine the need or effectiveness of such medications. If this Program provides benefits for prescription drugs the ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable to the prescription drug coverage. If this Program does not provide coverage for prescription drugs, ASD medications may be purchased at a pharmacy, and the Member will be reimbursed at 100% less the applicable Coinsurance amount shown in the **Schedule of Covered Services**. Benefits are available for up to a 30 day supply.
- Psychiatric Care - Direct or consultative services provided by a Physician who specializes in psychiatry.
- Psychological Care - Direct or consultative services provided by a Psychologist.
- Rehabilitative Care - Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- Therapeutic Care - Services provided by speech language pathologists, occupational therapists or physical therapists.

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Member shall be entitled to file an Appeal. The Appeal process will:

- Provide internal review followed by independent external review; and
- Have levels, expedited and standard Appeal time frames, and other terms established by the Health Benefit Plan consistent with applicable Pennsylvania and federal law.

Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits. Full Appeal process descriptions will be provided after a new Appeal is initiated and can also be obtained at any time by contacting Member Services.

Colorectal Cancer Screening

The Health Benefit Plan will provide coverage for colorectal cancer screening for Symptomatic Members, Nonsymptomatic Members over age 50, and Nonsymptomatic Members under age 50 who are at high risk or increased risk for colorectal cancer. Coverage for colorectal cancer screening must be in accordance with the current American Cancer Society guidelines, and

consistent with approved medical standards and practices. The method and frequency of screening to be utilized shall be:

- Coverage for Symptomatic Members shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.
- Coverage for Nonsymptomatic Members over age 50 shall include, but not be limited to:
 - An annual fecal occult blood test;
 - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and
 - A colonoscopy at least once every ten years.
- Coverage for Nonsymptomatic Members under age 50 who are at high or increased risk for colorectal cancer shall include a colonoscopy or any combination of colorectal cancer screening tests.

"Nonsymptomatic Member at high or increased risk" means a Member who poses a higher than average risk for colorectal cancer according to the current American Cancer Society guidelines on screening for colorectal cancer.

"Symptomatic Member" means a Member who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Consumable Medical Supplies

The Health Benefit Plan will provide coverage for the purchase of Consumable Medical Supplies when:

- It is used in the Member's home; and
- It is obtained through a Professional Provider.

Diabetic Education Program

When prescribed by a Professional Provider legally authorized to prescribe such items under law, the Health Benefit Plan will provide coverage for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; and
- Noninsulin-using diabetes.

When Physician certification must occur: The attending Physician must certify that a Member requires diabetic education on an Outpatient basis, under the following circumstances:

- Upon the initial diagnosis of diabetes;
- Upon a significant change in the Member's symptoms or condition; or
- Upon the introduction of new medication or a therapeutic process in the treatment or management of the Member's symptoms or condition.

Requirements that must be met: Outpatient diabetic education services will be covered when they meet specific requirements.

- These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

- Specific requirements: Outpatient diabetic education services and education program must:
 - Be provided by an In-Network Provider; and
 - Be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Health Benefit Plan.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ Initial assessment of the Member's needs; ▪ Family involvement and/or social support; ▪ Psychological adjustment for the Member; ▪ General facts/overview on diabetes; ▪ Prevention and treatment of complications for chronic diabetes, (That is, foot, skin and eye care); | <ul style="list-style-type: none"> ▪ Nutrition including its impact on blood glucose levels; ▪ Exercise and activity; ▪ Medications; ▪ Monitoring and use of the monitoring results; ▪ Use of community resources; and ▪ Pregnancy and gestational diabetes' if applicable |
|--|--|

Diabetic Equipment and Supplies

- Coverage and costs: The Health Benefit Plan will provide coverage for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. This is subject to any applicable Deductible, Copayment and/or Coinsurance requirements applicable to Durable Medical Equipment benefits.
- When diabetic equipment and supplies can be purchased at a pharmacy: If this Program provides benefits for prescription drugs (other than coverage for insulin and oral agents only):
 - Certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, if available;
 - This will be subject to the cost-sharing arrangements, applicable to the prescription drug coverage.
- When diabetic equipment and supplies are not available at a pharmacy:
 - The diabetic equipment and supplies will be provided under the Durable Medical Equipment benefit;
 - This will be subject to the cost-sharing arrangements applicable to Durable Medical Equipment.
- Covered Diabetic Equipment:
 - Blood glucose monitors;
 - Insulin pumps;
 - Insulin infusion devices; and
 - Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

- Covered Diabetic Supplies:
 - Blood testing strips;
 - Visual reading and urine test strips;
 - Insulin and insulin analogs*;
 - Injection aids;
 - Insulin syringes;
 - Lancets and lancet devices;
 - Monitor supplies;
 - Pharmacological agents for controlling blood sugar levels*;
 - and Glucagon emergency kits.

* **Note:** If this Program does not provide coverage for prescription drugs, insulin and oral agents are covered as provided under the 'Insulin and Oral Agents' benefits.

Diagnostic Services

The Health Benefit Plan will provide coverage for the following Diagnostic Services, when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

- Routine Diagnostic Services, including, but not limited to:
 - Routine radiology: Consisting of x-rays, mammograms, ultrasound, and nuclear medicine;
 - Routine medical procedures: Consisting of ECG, EEG and other diagnostic medical procedures approved by the Health Benefit Plan; and
 - Allergy testing: Consisting of percutaneous, intracutaneous and patch tests.
- Non-Routine Diagnostic Services, including, but not limited to:
 - Nuclear Cardiology Imaging;
 - MRI/MRA;
 - CT Scans;
 - PET Scans; and
 - Sleep Studies.
- Diagnostic laboratory and pathology tests.
- Genetic testing and counseling.
This includes services provided to a Member at risk for a specific disease that is a result of:
 - Family history; or
 - Exposure to environmental factors that are known to cause physical or mental disorders.

When clinical usefulness of specific genetic tests has been established by the Health Benefit Plan, these services are covered for the purpose of:

- Diagnosis;
- Screening;
- Predicting the course of a disease;
- Judging the response to a therapy;
- Examining risk for a disease; or
- Reproductive decision-making.

Durable Medical Equipment

The Health Benefit Plan will provide coverage for the rental or, at the option of the Health Benefit Plan, the purchase of Durable Medical Equipment when:

- Prescribed by a Professional Provider and required for therapeutic use; and
- Determined to be Medically Necessary by the Health Benefit Plan.

Although an item may be classified as Durable Medical Equipment it may not be covered in every instance. Durable Medical Equipment, as defined in the **Important Definitions** section, that includes equipment that meets the following criteria:

- It is durable and can withstand repeated use. An item is considered durable if it can withstand: repeated use, (That is, the type of item that could normally be rented). Medical Supplies of an expendable nature are not considered "durable" (For example, see the "Non-reusable supplies" provisions of the "Durable Medical Equipment" exclusion of the

Exclusions - What Is Not Covered section of this Program);

- It customarily and primarily serves a medical purpose;
 - It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Member's illness, injury, or to improvement of a malformed body part; and
 - It is appropriate for home use.
- Replacement and Repair:
The Health Benefit Plan will provide coverage for the repair or replacement of Durable Medical Equipment when the equipment does not function properly; and is no longer useful for its intended purpose, in the following limited situations:
- Due to a change in a Member's condition: When a change in the Member's condition requires a change in the Durable Medical Equipment the Health Benefit Plan will provide repair or replacement of the equipment;
 - Due to breakage: When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Health Benefit Plan will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Health Benefit Plan.

Breakage under warranty: If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:

- The Health Benefit Plan in the case of rented equipment; and
- The Member in the case of purchased equipment.

Breakage during reasonable useful lifetime: The Health Benefit Plan will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty. (For example, the Health Benefit Plan will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.)

Cost to repair vs. cost to replace: The Health Benefit Plan will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment:

- Replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning;
- A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

Emergency Care Services

- The In-Network level of benefits provided: Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Health Benefit Plan. They are provided at the In-Network level of benefits, regardless of whether the Member is treated by a In-Network or Out-of-Network Provider.
- Where to call and where to go: If Emergency Services are required, whether the Member is located in or outside the Personal Choice Network service area: Call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.
- What Emergency Care is: Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency.

- Examples of an Emergency include:
 - Heart attack;
 - Loss of consciousness or respiration;
 - Cardiovascular accident;
 - Convulsions;
 - Severe Accidental Injury; and
 - Other acute medical conditions as determined by the Health Benefit Plan.

Note: Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency: The determination by the Health Benefit Plan shall be final.

Home Health Care

- **Covered Services:** The Health Benefit Plan will provide coverage for the following services when performed by a licensed Home Health Care Provider:
 - Professional services of appropriately licensed and certified individuals;
 - Intermittent skilled nursing care;
 - Physical Therapy;
 - Speech Therapy;
 - Well mother/well baby care following release from an Inpatient maternity stay; and
 - Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.
- **Regarding well mother/well baby care:** With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if:
 - Discharge occurs earlier than 48 hours of a vaginal delivery; or
 - Discharge occurs earlier than 96 hours of a cesarean delivery.
 No cost-sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.
- **Regarding other medical services and supplies:** The Health Benefit Plan will also provide coverage for certain other medical services and supplies, when provided along with a primary service. Such other services and supplies include:
 - Occupational Therapy;
 - Medical social services; and
 - Home health aides in conjunction with skilled services and other services which may be approved by the Health Benefit Plan.
- **Regarding Medical Necessity:** Home Health Care benefits will be provided only when prescribed by the Member's attending Physician, in a written Plan Of Treatment and approved by the Health Benefit Plan as Medically Necessary.
- **Regarding the issue of being confined:** There is no requirement that the Member be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.
- **Regarding being Homebound:** With the exception of Home Health Care provided to a Member, immediately following an Inpatient release for maternity care, the Member must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

Limitations: This benefit is subject to the limits shown in the ***Schedule of Covered Services***.

Injectable Medications

The Health Benefit Plan will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a Professional Provider.

- Specialty Drugs

- Refer to a medication that meets certain criteria including, but not limited to:
 - The drug is used in the treatment of a rare, complex, or chronic disease;
 - A high level of involvement is required by a healthcare provider to administer the drug;
 - Complex storage and/or shipping requirements are necessary to maintain the drug's stability;
 - The drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance; and
 - Access to the drug may be limited.

To obtain a list of Specialty Drugs please logon to www.ibx.com/preapproval or Call the Customer Service telephone number shown on the Member's Identification Card.

- Copayments and Coinsurance apply:
 - The purchase of all Specialty Drugs is subject to:
 - ❖ A Copayment, if dispensed by an In-Network Provider; or
 - ❖ Coinsurance, if dispensed by an Out-of-Network Provider.
 - The Copayment and Coinsurance amounts are shown in the **Schedule of Covered Services**.
- Copayment and Coinsurance amounts will apply:
 - To each 30 day supply of medication dispensed for medications administered on a regularly scheduled basis; or
 - To each course/series of injections if administered on an intermittent basis.

A 90 day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness; in such a case, the Member will be subject to three Copayments, if applicable.

- Standard Injectable Drugs

- Standard Injectable Drugs refer to a medication that is either injectable or infusible, but is not defined by the Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug.
- Standard Injectable Drugs include, but are not limited to:
 - Allergy injections and extractions; and
 - Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.
- Self-Administered Prescription Drugs generally are not covered.
- For more information on Self-Administered Prescription Drugs:
 - Please refer to the **Exclusions - What Is Not Covered** section and the description of "Insulin and Oral Agents" coverage in the **Description of Covered Services** section.

Insulin and Oral Agents

The Health Benefit Plan will provide coverage for Insulin and oral agents to control blood sugar as prescribed by a Physician and dispensed by a licensed pharmacy. Benefits are available for up to a 30 day supply when dispensed from a retail pharmacy.

Medical Foods and Nutritional Formulas

- The Health Benefit Plan will provide coverage for Medical Foods when provided for the therapeutic treatment of inherited errors of metabolism (IEMs) such as:
 - Phenylketonuria;
 - Branched-chain ketonuria;
 - Galactosemia; and
 - Homocystinuria.

Coverage is provided when administered on an Outpatient basis, either orally or through a tube.

- The Health Benefit Plan will provide coverage for Nutritional Formulas when the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

The Health Benefit Plan will provide coverage for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment supplier or in connection with Infusion Therapy as provided for in this Program.

An estimated basal caloric requirement for Medical Foods and Nutritional Formula is not required for IEMs, or for when administered through a tube.

Non-Surgical Dental Services

The Health Benefit Plan will provide coverage only for:

- The initial treatment of Accidental Injury/trauma, (That is, fractured facial bones and fractured jaws), in order to restore proper function.

Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, required for the initial treatment for the Accidental Injury/trauma. This includes:

- The first caps;
- Crowns;
- Bridges; and
- Dentures (but not dental implants).

- The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. Injury as a result of chewing or biting is not considered an Accidental Injury. See the exclusion of dental services in the ***Exclusions - What Is Not Covered*** section for more information on what dental services are not covered.

Orthotics (Devices Used for Support of Bones and Joints)

The Health Benefit Plan will provide coverage for:

- The first purchase and fitting: This is the initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Health Benefit Plan. This does not include foot orthotics, unless the Member requires foot orthotics as a result of diabetes.
- Replacements due to growth: The replacement of covered orthotics for Dependent children when required due to natural growth.

Podiatric Care

The Health Benefit Plan will provide coverage for:

- Capsular or surgical treatment of bunions;
- Ingrown toenail Surgery; and
- Other non-routine Medically Necessary foot care.

In addition, for Members with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are covered.

Prosthetic Devices

The Health Benefit Plan will provide coverage for expenses Incurred for Prosthetic Devices (except dental prostheses) required as a result of illness or injury. Expenses for Prosthetic Devices are subject to medical review by the Health Benefit Plan to determine eligibility and Medical Necessity.

Such expenses may include, but not be limited to:

- The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ;
- The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
- Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive Surgery incident and subsequent to mastectomy; and
- Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
 - Initial contact lenses prescribed for treatment of infantile glaucoma;
 - Initial pinhole glasses prescribed for use after Surgery for detached retina;
 - Initial corneal or scleral lenses prescribed:
 - In connection with the treatment of keratoconus; or
 - To reduce a corneal irregularity other than astigmatism;
 - Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 - Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of:
 - Accidental Injury;
 - Trauma; or
 - Ocular Surgery.

The repair and replacement provisions do not apply to this item.

Benefits for replacement of a Prosthetic Device or its parts will be provided:

- When there has been a significant change in the Member's medical condition that requires the replacement;
- If the prostheses breaks because it is defective;
- If the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer; or
- For a Dependent's child due to the normal growth process when Medically Necessary.

The Health Benefit Plan will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of the prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Health Benefit Plan will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

If a Prosthetic Device breaks and is under warranty, it is the responsibility of the Member to work with the manufacturer to replace or repair it.

Specialist Office Visit

The Health Benefit Plan will provide coverage for Specialist Services Medical Care provided in the office by a Provider other than a Primary Care Provider.

For the purpose of this benefit "in the office" includes:

- Medical Care visits to a Provider's office;
- Medical Care visits by a Provider to the Member's residence; or
- Medical Care consultations by a Provider on an Outpatient basis.

Spinal Manipulation Services

The Health Benefit Plan will provide coverage for the detection and correction of structural imbalance or dislocation (subluxation) of the Member's spine resulting from, or related to any of the following:

- Distortion of, or in, the vertebral column;
- Misalignment of, or in, the vertebral column; or
- Dislocation (Subluxation) of, or in, the vertebral column.

The detection and correction can be done by: Manual or mechanical means (by hand or machine).

This service will be provided for, up to the limits specified in the ***Schedule of Covered Services*** for spinal manipulations.

Telemedicine Services

- Services Provided by MDLIVE®
Telemedicine services are provided by MDLIVE®, a national network of board certified physicians that provide consultations 24 hours a day, 7 days a week, 365 days a year. MDLIVE® physicians provide standard medical assessments, treatments, care and services to patients via the telephone or secure video when a primary care physician is unavailable or inaccessible. MDLIVE® does not replace an existing primary care physician relationship but enhances it with an efficient, cost-effective alternative for non-emergency medical problems. The applicable cost-sharing requirements are specified in the ***Schedule of Covered Services***. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.
- Benefits Provided by Professional Provider
Telemedicine services are also covered, when provided by a Professional Provider and subject to the relevant cost-share applicable to that Provider. The Provider's eligibility will be determined by the Health Benefit Plan in the Health Benefit Plan's policies, who is licensed

in the state where the telemedicine service is being offered. Telemedicine services are covered when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA) - compliant interactive audio and video telecommunications system as specified in the Health Benefit Plan's policies

Therapy Services

The Health Benefit Plan will provide coverage, subject to the Benefit Period Maximums specified in the ***Schedule of Covered Services***, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Member.

- **Cardiac Rehabilitation Therapy**
Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- **Chemotherapy**
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided if it meets all of the criteria listed below:
 - Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents;
 - The FDA approved indication is based on reliable evidence demonstrating positive effect on health outcomes and/or the indication is supported by the established referenced Compendia identified in the Health Benefit Plan's policies; and
 - Drugs/biologics are eligible for coverage when they are injected or infused into the body by a Professional Provider.

Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic agents are covered as provided under the benefits described above.

- **Dialysis**
The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).
- **Infusion Therapy**
The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a Professional Provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (For example, home, office, Outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of Professional Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Health Benefit Plan.

- Occupational Therapy
Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.
- Physical Therapy
Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part, including the treatment of functional loss following hand and/or foot Surgery.
- Pulmonary Rehabilitation Therapy
Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.
- Radiation Therapy
The treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.
- Respiratory Therapy
Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.
- Speech Therapy
Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Urgent Care Centers

The Health Benefit Plan will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Health Benefit Plan.

- Urgent Care Centers are designed to offer immediate evaluation and treatment for health conditions that require medical attention:
 - In a non-Emergency situation;
 - That cannot wait to be addressed by the Member's Professional Provider or Retail Clinic.
- Cost-sharing requirements are specified in the ***Schedule of Covered Services***.

EXCLUSIONS – WHAT IS NOT COVERED

Except as specifically provided in this Benefit Booklet, no benefits will be provided for services, supplies or charges:

Alternative Therapies/Complementary Medicine

For Alternative Therapies/Complementary Medicine, including but not limited to:

- Music therapy;
- Dance therapy;
- Equestrian/hippotherapy;
- Homeopathy;
- Primal therapy;
- Rolfing;
- Psychodrama;
- Vitamin or other dietary supplements and therapy;
- Naturopathy;
- Hypnotherapy;
- Bioenergetic therapy;
- Qi Gong;
- Ayurvedic therapy;
- Aromatherapy;
- Massage therapy;
- Therapeutic touch;
- Recreational, wilderness, educational and sleep therapies.

Ambulance Services

For ambulance services except as specifically provided under this Program.

Assisted Fertilization Techniques

For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT).

Autism

- For Autism Spectrum Disorders services that exceed the Annual Benefit Maximum shown in the ***Schedule of Covered Services***.
- For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
- For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

Benefit Maximums

For charges Incurred for expenses in excess of Benefit Maximums as specified in the ***Schedule of Covered Services***.

Chronic Conditions

- For Maintenance of chronic conditions, injuries or illness.

- For any Therapy Service provided for:
 - Ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement;
 - Additional therapy beyond the Program's limits, if any, shown on the **Schedule Of Covered Services** (EXCEPT for services provided for Autism Spectrum Disorders which have no visit limits);
 - Work hardening;
 - Evaluations not associated with therapy; or
 - Therapy for back pain in pregnancy without specific medical conditions.

Cognitive Rehabilitation Therapy

For Cognitive Rehabilitation Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy).

Consumable Medical Supplies

For Consumable Medical Supplies, any item that meets the following criteria is not a covered Consumable Medical Supply and will not be covered:

- The item is for comfort or convenience.
- The item is not primarily medical in nature. Items not covered include, but are not limited to:
 - Ear plugs;
 - Ice pack;
 - Silverware/utensils;
 - Feeding chairs; and
 - Toilet seats.
- The item has features of a medical nature which are not required by the member's condition.
- The item is generally not prescribed by an eligible Provider.

Some examples of not covered Consumable Medical Supplies are:

- Incontinence pads;
- Lamb's wool pads;
- Face masks (surgical);
- Disposable gloves, sheets and bags;
- Bandages;
- Antiseptics; and
- Skin preparations.

Cosmetic Surgery

For services and operations for cosmetic purposes

- Which are done to improve the appearance of any portion of the body; and
- From which no improvement in physiologic function can be expected.

However, benefits are payable to correct:

- A condition resulting from an accident; and
- Functional impairment which results from a covered disease, injury or congenital birth defect.

This exclusion does not apply to mastectomy related charges as provided for and defined in the "Surgical Services" section in the **Description of Covered Services**.

Cranial Protheses (Including Wigs)

For cranial protheses, including wigs intended to replace hair.

Day Rehabilitation Program

For Day Rehabilitation Program services.

Dental Care

- For dental services related to:
 - The care, filling, removal or replacement of teeth, including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta; and
 - The treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this Benefit Booklet.
 - Specific services not covered include, but are not limited to (unless otherwise described in this Benefit Booklet):
 - Apicoectomy (dental root resection);
 - Prophylaxis of any kind;
 - Root canal treatments;
 - Soft tissue impactions;
 - Alveolectomy;
 - Bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and
 - Treatment of periodontal disease;
- For dental implants for any reason.
- For dentures, unless for the initial treatment of an Accidental Injury/trauma.
- For Orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.
- For injury as a result of chewing or biting (neither is considered an Accidental Injury).

Diagnostic Screening Examinations

For diagnostic screening examinations, except for mammograms and preventive care as provided in the "Primary and Preventive Care", "Women's Preventive Care" and "Diagnostic Services" subsections of the **Description of Covered Services**.

Durable Medical Equipment

For the following examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

- Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
- Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
- Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as:
 - Diathermy machines;
 - Medcolator;
 - Data transmission devices used for telemedicine purposes;
 - Pulse tachometer;
 - Translift chairs; and

- Traction units.
- Non-reusable supplies other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment.
- Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to:
 - Equipment For Safety;
 - Exercise equipment;
 - Speech teaching machines;
 - Strollers;
 - Toileting systems;
 - Electronically-controlled heating and cooling units for pain relief;
 - Bathtub lifts;
 - Stairglides; and
 - Elevators.
- Equipment with features of a medical nature which are not required by the Member's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medical Necessity and realistically feasible alternative item that serves essentially the same purpose.
- Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.
- Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.
- Modifications to vehicles, dwellings and other structures. This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Member's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as customization to a wheelchair.

Effective Date

Which were Incurred prior to the Member's Effective Date of coverage.

Experimental/Investigative

Which are Experimental/Investigative in nature, except, as approved by the Health Benefit Plan, Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Benefit Booklet.

Foot Orthotics

For supportive devices for the foot (orthotics), such as, but not limited to:

- Foot inserts;
- Arch supports;
- Heel pads and heel cups; and
- Orthopedic/corrective shoes.

This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes.

Hospice Care

For Hospice Care benefits for the following:

- Services and supplies for which there is no charge;
- Research studies directed to life lengthening methods of treatment;
- Services or expenses Incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other disposition of personal and real property);
- Care provided by family members, relatives, and friends; and
- Private Duty Nursing.

Immediate Family

Rendered by a member of the Member's Immediate Family.

Immunizations for Employment or Travel

For Immunizations required for employment purposes or travel.

Medical Foods And Nutritional Formulas

- For appetite suppressants;
- For oral non-elemental nutritional supplements (For example, Boost, Ensure, NeoSure, PediaSure, Scandishake), casein hydrolyzed formulas (For example, Nutramigen, Alimentun, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, and soy-based products. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the **Description of Covered Services**;
- For elemental semi-solid foods (For example, Neocate Nutra);
- For products that replace fluids and electrolytes (For example, Electrolyte Gastro, Pedialyte);
- For oral additives (For example, Duocal, fiber, probiotics, or vitamins) and food thickeners (For example, Thick-It, Resource ThickenUp); and
- For supplies associated with the oral administration of formula (For example, bottles, nipples).

Medical Supplies

For Medical Supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

Medical Necessity

Which are not Medically Necessary as determined by the Health Benefit Plan for the diagnosis or treatment of illness or injury.

Mental Health/Psychiatric Care

- For vocational or religious counseling; and
- For activities that are primarily of an educational nature.

Military Service

For any loss sustained or expenses Incurred in the following ways:

- During military service while on active duty as a member of the armed forces of any nation; or
- As a result of enemy action or act of war, whether declared or undeclared.

Miscellaneous

- For care in a:
 - Nursing home;
 - Home for the aged;
 - Convalescent home;
 - School;
 - Camp;
 - Institution for intellectually disabled children; or
 - Custodial Care in a Skilled Nursing Facility.
- For broken appointments.
- For Telephone consultations.
- For completion of a claim form.
- For marriage counseling.
- For Custodial Care, domiciliary care or rest cures.
- Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Service Provider" except as otherwise indicated under the subsections entitled:
 - "Therapy Services"; and
 - "Ambulance Services" in the **Description of Covered Services** section.
- Performed by a Professional Provider enrolled in an education or training program when such services are:
 - Related to the education or training program; and are
 - Provided through a Hospital or university.
- For weight reduction and premarital blood tests. This exclusion does not apply to nutrition visits as set forth in the **Description of Covered Services** section under the subsection entitled "Nutrition Counseling for Weight Management".

Motor Vehicle

For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is:

- Paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan; or
- Payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.

Non-Covered Services

Any services, supplies or treatments not specifically listed as covered benefits in this Program.

Obesity

For treatment of obesity, including surgical treatment of obesity.

This exclusion does not apply to nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

Orthoptic/Pleoptic Therapy

For treatment associated with Orthoptic/Pleoptic Therapy.

Over-The-Counter Drugs

For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Admission. This exclusion does not apply to over-the-counter medicines that are prescribed by a Physician in accordance with applicable law.

Personal Hygiene and Convenience Items

For personal hygiene and convenience items such as, but not limited to the following, whether or not recommended by a Provider:

- Air conditioners;
- Humidifiers;
- Physical fitness or exercise equipment;
- Radio;
- Beauty/barber shop services;
- Guest trays;
- Wigs;
- Chairlifts;
- Stairglides;
- Elevators;
- Sauna;
- Television;
- Spa or health club memberships;
- Whirlpool;
- Telephone;
- Guest Service; or
- Hot tub or equivalent device.

Physical Examinations

For routine physical examinations for non-preventive purposes, such as:

- Pre-marital examinations;
- Physicals for college;
- Camp or travel; and
- Examinations for insurance, licensing and employment.

Prescription Drugs

- For prescription drugs, except as may be provided by a prescription drug rider attached to this Benefit Booklet. This exclusion does NOT apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels, as provided for the treatment of diabetes and contraceptive methods, including contraceptive drugs and devices, injectable contraceptives, IUDs and implants; sterilization procedures, and patient education and counseling, not including abortifacient drugs, for generic products and for those methods that do not have a generic equivalent. Brand contraceptives are excluded.
- For drugs and medicines for which the Member has coverage under a free-standing prescription drug program provided through the Enrolled Group.

Private Duty Nursing

For Inpatient and Outpatient Private Duty Nursing services.

Relative Counseling or Consultations

For counseling or consultation with a Member's relatives, or Hospital charges for a Member's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol Or Drug Abuse And Dependency" or "Transplant Services" sections of the **Description of Covered Services**.

Responsibility of Another Party

- For which a Member would have no legal obligation to pay, or another party has primary responsibility.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

Responsibility of Medicare

Claims paid or payable by Medicare when Medicare is primary. For purposes of this Program exclusion, coverage is not available for a service, supply or charge that is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits. The amount excluded for these claims will be either the amount "payable under Medicare" or the applicable plan fee schedule for the service, at the discretion of the Health Benefit Plan.

Reversal of a Sterilization

For any Surgery performed for the reversal of a sterilization procedure.

Routine Foot Care

As defined in the Health Benefit Plan's Medical Policy unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

Self-Administered Prescription Drugs

For Self-Administered Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self-Administered Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration.

This exclusion does not apply to Self-Administered Prescription Drugs that are:

- Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by a Free-Standing Prescription Drug Contract issued to the Group by the Health Benefit Plan; or
- Required for treatment of an Emergency condition that requires a Self-Administered Prescription Drug.

Sexual Dysfunction

For sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist.

Skilled Nursing Facility

For Skilled Nursing Facility services in connection with the following:

- When confinement in a Skilled Nursing Facility is intended solely to assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
- For the treatment of Alcohol And Drug Abuse Or Dependency, and Mental Illness; or
- After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

Temporomandibular Joint Syndrome (TMJ)

For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension.

Termination Date

Which were or are Incurred after the date of termination of the Member's coverage except as provided in the **General Information** section.

Traditional Medical Management

For any care that extends beyond traditional medical management for:

- Autistic disease of childhood;
- Pervasive Developmental Disorders;
- Attention Deficit Disorder;
- Learning disabilities;
- Behavioral problems;
- Intellectual disability;
- Treatment or care to effect environmental or social change; or
- Autism Spectrum Disorders.

Except as otherwise provided in this Program.

Travel

For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider.

Veteran's Administration or Department of Defense

To the extent a Member is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Member.

Vision

- For correction of myopia or hyperopia by means of corneal microsurgery, such as:
 - Keratomileusis;
 - Keratophakia;
 - Radial keratotomy and all related services.
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Benefit Booklet.

Worker's Compensation

For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of:

- Worker's Compensation Law; or
- Any similar Occupational Disease Law or Act.

This exclusion applies whether or not the Member claims the benefits or compensation.

GENERAL INFORMATION

ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PROGRAM

Effective Date: The date the Group agrees that all eligible persons may apply and become covered for the benefits as set forth in this Program and described in this Benefit Booklet. If a person becomes an eligible person after the Group's Effective Date, that date becomes the eligible person's effective date under this Program.

Eligible Person

The Employee is eligible to be covered under this Program if the Employee is determined by the Group as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by the Employee's physical condition and determination of eligibility for the coverage by the employer shall be final and binding.

Eligible Dependent

The Employee's family is eligible for coverage (Dependent coverage) under this Program when the Employee is eligible for Employee coverage. An eligible Dependent is defined as the Employee's spouse under a legally valid existing marriage, the Employee's child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is the Employee's responsibility under the terms of a qualified release or court order. The limiting age for covered children is the first of the month following the month in which they reach age 26.

In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from an Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

A full-time student who is eligible for coverage under this Program who is:

- A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
- A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

As proof of eligibility, the Employee must submit a form to the Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
- Notifying the Health Benefit Plan that the Dependent is no longer on active duty; or
- Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his release from active duty.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on the Employee for over half of their support. The Health Benefit Plan may require proof of eligibility under the prior Health Benefit Plan's plan and also from time to time under this Program.

The newborn child(ren) of the Employee or the Employee's Dependent shall be entitled to the benefits provided by this Program from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, the Employee must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, the Employee must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under this Program on the date the Dependent is acquired provided that the Employee applies to the Health Benefit Plan for addition of the Dependent within 31 days after the Dependent is acquired and the Employee makes timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after the Employee's Application is accepted by the Health Benefit Plan.

A Dependent child of a custodial parent covered under this Program may be enrolled under the terms of a qualified medical release or court order, as required by law.

No Dependent may be eligible for coverage as a Dependent of more than one Member of the Enrolled Group. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

Benefits to Which the Member Is Entitled

The liability of the Health Benefit Plan is limited to the benefits specified in this Benefit Booklet. The Health Benefit Plan's determination of the benefit provisions applicable for the services rendered to the Member shall be conclusive.

Termination of Coverage at Termination Of Employment Or Membership In The Group

When a Member ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Health Benefit Plan before the Health Benefit Plan receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days

before the first day of the month in which the Group notified the Health Benefit Plan of such termination.

Consumer Rights

Each Member has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number referenced on the Identification Card.

Member/Provider Relationship

- The choice of a Provider is solely the Member's choice.
- The Health Benefit Plan does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Program. The Health Benefit Plan is not liable for any act or omission of any Provider. The Health Benefit Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

COVERAGE CONTINUATION

Termination of the Member's Coverage and Conversion Privilege Under This Program

- Termination of this Program – Termination of the Group coverage (this Program) automatically terminates all coverage for the Member (an Enrolled Employee) and the Member's eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Member who has been continuously covered under the Contract for at least three months (or covered for similar benefits under any group plan that this Program replaced).

It is the responsibility of the Group or the Group's Applicant Agent to notify the Member and the Member's eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

Rescission: If it is proven that the Member or the Member's eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation of material fact, the Health Benefit Plan, may, upon notice to the Member, terminate the coverage. The Member will receive written notice at least 30 days prior to termination but will have the right to utilize the **Complaint and Appeal Process** to appeal cancellation.

The privilege of conversion is available for the Member and the Member's eligible Dependents except in the following circumstances:

- The Group terminates this Program in favor of group coverage by another organization;
or
 - The Group terminates the Member in anticipation of terminating this Program in favor of group coverage by another organization.
- Notice of Conversion – Written notice of termination and the privilege of conversion to a conversion contract shall be given within 15 days before or after the date of termination of this Program, provided that if such notice is given more than 15 days but less than 90 days after the date of termination of this Program, the time allowed for the exercise of the

privilege of conversion shall be extended for 15 days after the giving of such notice. Payment for coverage under the conversion contract must be made within 31 days after the coverage under this Program ends. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of the Member's termination under this Program.

Conversion coverage shall not be available if the Member is eligible for another health care program which is available in the Group where the Member is employed or with which the Member is affiliated to the extent that the conversion coverage would result in over-insurance.

If the Member's coverage or the coverage of the Member's eligible dependent terminates because of the Member's death, the Member's change in employment status, divorce of dependent spouse, or change in a dependent's eligibility status, the terminated Member will be eligible to apply within 31 days of termination (or termination of the continuation privileges under COBRA) to conversion coverage, of the type for which that Member is then qualified at the rate then in effect. This conversion coverage may be different from the coverage provided under this Program. Evidence of insurability is not required.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

The Member's protection under this Program may be extended after the date the Member ceases to be a Member under this Program because of termination of employment or membership in the Group. It will be extended if, on that date, the Member is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the Member remains Totally Disabled from any such illness or injury, but not beyond 12 months if the Member ceases to be a Member because the Member's coverage under this Program ends.

Coverage under this Program will apply during an extension as if the Member was still a Member. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for the Member through the Health Benefit Plan by the Group. Continuation of coverage is subject to payment of the applicable premium.

Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member (an enrolled Employee) for over half of the child's support, the Member may apply to the Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 26.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 26 years of age. The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 26 years of age and joining the Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Pennsylvania Act 62 Of 2009 (Mini-COBRA)

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two to 19 Employees.

For purposes of this subsection, a “qualified beneficiary” means any person who, before any event which would qualify that person for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- A covered Employee;
- The Employee's spouse; or
- The Employee's Dependent child.

In addition, any child born to or placed for adoption with the Employee during Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Program during Mini-COBRA continuation, other than a child born to or placed for adoption with the Employee during Mini-COBRA continuation, will not be a qualified beneficiary.

- If An Employee Terminates Employment or Has a Reduction of Work Hours: If the Employee's group benefits end due to the Employee's termination of employment or reduction of work hours, the Employee may be eligible to continue such benefits for up to nine months, if:
 - The Employee's termination of employment was not due to gross misconduct;
 - The Employee is not eligible for coverage under Medicare;
 - The Employee verifies that the Employee is not eligible for group health benefits as an eligible dependent; and
 - The Employee is not eligible for group health benefits with any other carrier.

The continuation will cover the Employee and any other qualified beneficiary who loses coverage because of the Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the “When Continuation Ends” paragraph of this subsection.

- The Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
 - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
 - The Employee's death;
 - The Employee's divorce or legal separation from an eligible dependent;
 - The Employee becomes eligible for benefits under Social Security;
 - The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;

- Commencement of Employer's bankruptcy proceedings.

The notice must be given to the Employee, the plan administrator and the Health Benefit Plan no later than 30 days of any of these events.

- The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Employer.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If an Employee Dies: If the covered Employee dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the 'When Continuation Ends' paragraph of this subsection.
- If an Employee's Marriage Ends: If the Employee's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.
- If a Dependent Loses Eligibility: If the Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the 'When Continuation Ends' paragraph of this subsection.
- Election of Continuation: To continue the qualified beneficiary's group health benefits, the qualified beneficiary must give the plan administrator written notice that the qualified beneficiary elects to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of the qualified beneficiary's continuation rights from the plan administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Health Benefit Plan of the qualified beneficiary's election of continuation within 14 days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the plan administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the plan administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

- Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.
- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program ends on the first to occur of the following:
 - With respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - With respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - With respect to the Employee's Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - The date coverage under this Program ends;
 - The end of the period for which the last premium payment is made;
 - The date the qualified beneficiary becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
 - The date the Employee and/or eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BENEFIT BOOKLET.

THE HEALTH BENEFIT PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

The Member's Personal Choice Network Plan (this Program) is a program, which allows the Member to maximize the Member's health care benefits by utilizing the Personal Choice Network, which is comprised of Providers that have a contractual arrangement with the Health Benefit Plan. These Providers are called "In-Network Providers". In-Network Providers are doctors, Hospitals and other health care professionals and institutions that are part of the Personal Choice Network, which is designed to provide access to care through a selected managed network of Providers. Services by In-Network Providers are delivered through a selected, managed network of Providers designed to provide quality care. The Personal Choice Network includes Hospitals, Primary Care Physicians and specialists, and a wide range of Ancillary Service Providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care Agencies, Skilled Nursing Facilities, Free Standing Dialysis Facilities and Ambulatory Surgical Facilities.

When the Member receives health care through a Provider that is a member of the Personal Choice Network, the Member incurs limited out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if the Member chooses to receive health care through a Provider that is not an In-Network Provider. However, the level of benefits will be reduced, and the Member will be responsible for a greater share of out-of-pocket expenses, and the amount of the Member's expenses could be substantial. The Member may have to reach a Deductible before receiving benefits, and the Member may be required to file a claim form.

A directory of the In-Network Providers who belong to the Personal Choice Network is available to the Member upon request. It will identify the Professional Providers who have agreed to become In-Network Professional Providers and will also identify the Hospitals in the Network with which the In-Network Professional Providers are affiliated. Also included in the directory is a listing of the Ancillary Service Providers affiliated with the Personal Choice Network. The directory is updated periodically throughout the year, and the Health Benefit Plan reserves the right to add or delete Physicians and/or Hospitals at any given time. It is important to know that continued participation of any one doctor, Hospital or other Provider cannot be guaranteed. For information regarding Providers that participate in the Personal Choice Network, call 1-800-ASK BLUE (TTY: 711).

The Health Benefit Plan covers only care that is "Medically Necessary". Medically Necessary care is care that is needed for the Member's particular condition and that the Member receives at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and Hospital Outpatient Care.

Some of the services the Member receives through this Program must be Precertified before the Member receives them, to determine whether they are Medically Necessary. Failure to Precertify services to be provided by an Out-of-Network Provider, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews the Medically Necessary of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an Inpatient setting, in many different settings - such as an Outpatient department of a Hospital or a doctor's office.

When the Member seeks medical treatment that requires Precertification, the Member is not responsible for obtaining the Precertification if treatment is provided by an In-Network Provider (That is, a Provider in the Personal Choice Network). In addition, if the In-Network Provider fails to obtain a required Precertification of services, the Member will be held harmless from any associated financial Penalties assessed by the Program as a result. If the request for Precertification is denied, the Member will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If the Member decides to continue treatment or care that has not been approved, the Member will be asked to do the following:

- Acknowledge this in writing.
- Request to have services provided.
- State the Member's willingness to assume financial liability.

When the Member seeks treatment from an Out-of-Network Provider or a BlueCard Provider (excluding Inpatient Admissions), the Member is responsible for initiating the Precertification

process. The Member or the Member's Provider should call the Precertification number listed on the Member's Identification Card, and give their name, facility's name, diagnosis, and procedure or reason for admission. Failure to Precertify required services will result in a reduction of benefits payable to the Member.

Payment Of Providers

▪ In-Network Provider Reimbursement

Personal Choice reimbursement programs for health care Providers are intended to encourage the provision of quality, cost-effective care for Personal Choice members. Set forth below is a general description of Personal Choice reimbursement programs, by type of Personal Choice Network health care Provider.

Please note that these programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If the Member has any questions about how the Member's health care Provider is compensated, the Member should speak to their healthcare Provider directly or contact Customer Services.

– Physicians

Personal Choice Network Physicians, including Primary Care Provider (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Health Benefit Plan's Personal Choice fee schedule for the specific medical services that the Physician performs.

– Institutional Providers

Hospitals: For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, (For example, transplants). For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

The Health Benefit Plan implemented a quality incentive program with a few Hospitals. This program provides increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities: Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Member is in the facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Facilities (ASFs): Most ASFs are paid specific rates based on the type of Covered Service performed. For a few services, some ASFs are paid based on a percentage of billed charges.

- Physician Group Practices, Physician Associations and Integrated Delivery Systems Certain Physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual Physicians to provide medical services. These groups are paid as described in the Physician's reimbursement section outlined above. These groups may pay their affiliated Physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.
- Ancillary Service Providers, certain Facility Providers and Mental Health/Psychiatric Care and Alcohol Or Drug Abuse And Dependency Providers, Ancillary Service Providers, such as Durable Medical Equipment Providers, laboratory Providers, Home Health Care Agencies, and mental health/psychiatric care and Alcohol and Drug Abuse Providers are paid on the basis of fee-for-service payments according to the Health Benefit Plan's Personal Choice fee schedule for the specific Covered Services performed. In some cases, such as for mental health/psychiatric care and Alcohol and Drug Abuse benefits, one vendor arranges for all such services through a contracted set of providers. The Health Benefit Plan reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Blue Cross has less than a 3% ownership interest in this mental health/psychiatric care and Alcohol and Drug Abuse vendor.
- Payment of Out-of-Network Providers
For Covered Services received from an Out-of-Network Provider, payment will be made directly to the Member and the Member will be responsible for reimbursing the Out-of-Network Provider. However, Health Benefit Plan reserves the right, in its sole discretion, to make payments directly to the Out-of-Network Provider
- Payment Methods
A Member or the Provider may submit bills directly to the Health Benefit Plan, and, to the extent that benefits are payable within the terms and conditions of this Benefit Booklet, reimbursement will be furnished as detailed below. The Member's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.
- Facility Providers
 - In-Network Facility Providers
In-Network Facility Providers are members of the Personal Choice Network and have a contractual arrangement with the Health Benefit Plan for the provision of services to Members. Benefits will be provided as specified in the **Schedule of Covered Services** for Covered Services which have been performed by an In-Network Facility Provider. The Health Benefit Plan will compensate In-Network Facility Providers in accordance with the contracts entered into between such Providers and the Health Benefit Plan. BlueCard Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Member for Covered Services rendered by any In-Network Facility Provider.
 - Out-of-Network Facility Providers

Out-of-Network Facility Providers include facilities that are not part of the Personal Choice Network. The Health Benefit Plan may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network.

The Health Benefit Plan will provide benefits for Covered Services provided by an Out-of-Network Facility Provider at the Out-of-Network Coinsurance level specified in the **Schedule of Covered Services**. The reimbursement rate is specified under "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

If the Health Benefit Plan determines that Covered Services were for Emergency Care as defined herein, the Member normally will not be subject to the cost-sharing Penalties that would ordinarily be applicable to Out-of-Network services. Emergency admissions must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Health Benefit Plan. Payment for Emergency Services provided by Out-of-Network Providers will be the greater of:

- ❖ The median of the amounts paid to In-Network Providers for Emergency Services;
- ❖ The amount paid to Out-of-Network Facility Providers; or
- ❖ The amount paid by Medicare.

Once Covered Services are rendered by a Facility Provider, the Health Benefit Plan will not honor a Member's request not to pay for claims submitted by the Facility Provider. The Member will have no liability to any person because of its rejection of the request.

– Professional Providers

➤ In-Network Providers

The Health Benefit Plan is authorized by the Member to make payment directly to the In-Network Professional Providers furnishing Covered Services for which benefits are provided under this Program. In-Network Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. In-Network Professional Providers will make no additional charge to Members for Covered Services except in the case of certain Copayments, Coinsurance or other cost-sharing features as specified under this Program. The Member is responsible within 60 days of the date in which the Health Benefit Plan finalizes such services to pay, or make arrangements to pay, such amounts to the In-Network Professional Provider.

Benefit amounts, as specified in the **Schedule of Covered Services** of this Program, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the In-Network Professional Provider and a Member with respect to balance billing shall be submitted to the Health Benefit Plan for determination. The decision of the Health Benefit Plan shall be final.

Once Covered Services are rendered by a Professional Provider, the Health Benefit Plan will not honor a Member's request not to pay for claims submitted by the Professional Provider. The Health Benefit Plan will have no liability to any person because of its rejection of the request.

- **Emergency Care by Out-of-Network Providers**

If the Health Benefit Plan determines that Covered Services provided by an Out-of-Network Provider were for Emergency Care, the Member will be subject to the In-Network cost-sharing levels. Penalties that ordinarily would be applicable to Out-of-Network Covered Services will not be applied. For Emergency Care, the Health Benefit Plan will reimburse the Member for Covered Services at the Out-of-Network Provider reimbursement rate. However, if Emergency Care is provided by certain Out-of-Network Providers (For example, ambulance services), in accordance with applicable law, the Health Benefit Plan will reimburse the Out-of-Network Provider at an In-Network rate directly. In this instance the specified Out-of-Network Provider will not bill the Member for amounts in excess of the Health Benefit Plan's payment for the Emergency Care. For payment of Covered Services provided by an Out-of-Network Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Health Benefit Plan Payment for Emergency Services provided by Out-of-Network Providers will be the greater of:

 - ❖ The median of the amounts paid to In-Network Providers for Emergency Services;
 - ❖ The amount paid to Out-of-Network Professional Providers; or
 - ❖ The amount paid by Medicare.

An Out-of-Network Provider who provided Emergency Care can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Health Benefit Plan's payment for the Emergency Care, (That is, balance billing). In such situations, the Member will need to contact the Health Benefit Plan at the Customer Service telephone number listed on the Member's I.D. card. Upon such notification, the Health Benefit Plan will resolve the balance-billing.

- **Out-of-Network Hospital-Based Provider Reimbursement**

When the Member receives Covered Services from an Out-of-Network Hospital-Based Provider while the Member is an Inpatient at an In-Network Hospital or other In-Network Facility Provider and are being treated by an In-Network Professional Provider, the Member will receive the In-Network cost-sharing level of benefits for the Covered Services provided by the Out-of-Network Hospital-Based Provider. For such Covered Services, payment will be made to the Member, who will be responsible for reimbursing the Out-of-Network Hospital-Based Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

An Out-of-Network Hospital-Based Provider can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Health Benefit Plan's payment to the Out-of-Network Hospital-Based Providers, (That is, balance billing). In such situations, the Member will need to contact the Health Benefit Plan at the Customer Service telephone number listed on the Member's I.D. card. Upon such notification, the Health Benefit Plan will resolve the balance billing.

Note that when the Member elects to see an Out-of-Network Hospital-Based Provider for follow-up care or any other service where the Member has the ability to select an In-Network Provider, the Covered Services will be covered at an Out-of-

Network benefit level. Except for Emergency Care, if an Out-of-Network Provider admits the Member to a Hospital or other Facility Provider, Covered Services provided by an Out-of-Network Hospital-Based Provider will be reimbursed at the Out-of-Network benefit level. For such Covered Services, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Hospital-Based Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

- **Inpatient Hospital Consultations by an Out-of-Network Professional Provider**
When the Member receives Covered Services for an Inpatient hospital consultation from an Out-of-Network Professional Provider while the Member is Inpatient at an In-Network Facility Provider, and the Covered Services are referred by an In-Network Professional Provider, the Member will receive the In-Network cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Professional Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

An Out-of-Network Professional Provider can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Health Benefit Plan's payment to the Out-of-Network Professional Providers, (That is, balance billing). In such situations, the Member will need to contact the Health Benefit Plan at the Customer Service telephone number listed on the Member's I.D. card. Upon such notification, the Health Benefit Plan will resolve the balance billing.

Note that when the Member elects to see an Out-of-Network Professional Provider for follow-up care or any other service when the Member has the ability to select an In-Network Provider, the Covered Services will be covered at an Out-of-Network benefit level. Except for Emergency Care, if an Out-of-Network Professional Provider admits the Member to a Hospital or other Facility Provider, services provided by Out-of-Network Professional Provider will be reimbursed at the Out-of-Network benefit level. For such Covered Services, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Professional Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

- **Out-of-Network Professional Provider Reimbursement**
Except as set forth above, when a Member seeks care from an Out-of-Network Professional Provider, benefits will be provided to the Member at the Out-of-Network Coinsurance level specified in the **Schedule of Covered Services**. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet. When a Member seeks care and receives Covered Services from an Out-of-Network Professional Provider, the Member will be responsible to reimburse the Out-of-Network Professional Provider for the difference between the Health Benefit Plan's payment and the Out-of-Network Professional Provider's charge.

- Ancillary Service Providers
 - In-Network Ancillary Service Providers

In-Network Ancillary Service Providers include members of the Personal Choice Network that have a contractual relationship with the Health Benefit Plan for the provision of services or supplies to Members. Benefits will be provided as specified in the **Schedule of Covered Services** for the provision of services or supplies provided to Members by In-Network Ancillary Service Providers. The Health Benefit Plan will compensate In-Network Ancillary Service Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the Health Benefit Plan. No payment will be made directly to the Member for Covered Services rendered by any In-Network Ancillary Service Provider.
 - Out-of-Network Ancillary Service Providers

Out-of-Network Ancillary Service Providers are not members of the Personal Choice Network. Benefits will be provided to the Member at the Out-of-Network Coinsurance level specified in the **Schedule of Covered Services**. The Member will be penalized by the application of higher cost-sharing as detailed in the **Schedule of Covered Services**. For payment of Covered Services provided by an Out-of-Network Ancillary Service Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet. When a Member seeks care and receives Covered Services from an Out-of-Network Ancillary Service Provider, the Member will be responsible to reimburse the Out-of-Network Ancillary Service Provider for the difference between the Health Benefit Plan's payment and the Out-of-Network Ancillary Service Provider's charge.
- Assignment of Benefits to Providers

The right of a Member to receive benefit payments under this Program is personal to the Member and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this Program be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under this Program, as required by law.

BlueCard Program

- Out-of-Area Services

Overview

QCC Insurance Company ("QCC") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever the Member accesses healthcare services outside of the geographic area QCC serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When the Member receives care outside of QCC's service area, the Member will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. QCC explains below how QCC pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by QCC to provide the specific service or services.

– BlueCard® Program

Under the BlueCard® Program, when the Member receives Covered Services within the geographic area served by a Host Blue, QCC will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When the Member receives Covered Services outside QCC's service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to QCC.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price QCC has used for the Member's claim because they will not be applied after a claim has already been paid.

– Special Cases: Value-Based Programs

BlueCard® Program

If the Member receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to QCC through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If QCC has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, QCC will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

– Nonparticipating Providers Outside QCC's Service Area

➤ Member Liability Calculation

When Covered Services are provided outside of QCC's service area by nonparticipating providers, the amount the Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment QCC will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

➤ Exceptions

In certain situations, QCC may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount QCC will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment QCC will make for the Covered Services as set forth in this paragraph.

– Blue Cross Blue Shield Global Core

If the Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Member may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Member with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when the Member receives care from providers outside the BlueCard service area, the Member will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If the Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

➤ Inpatient Services

In most cases, if the Member contacts the service center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for the Member's deductibles, coinsurance, etc. In such cases, the hospital will submit the Member's claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **The Member must contact QCC to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**
Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require the Member to pay in full at the time of service. The Member must submit a claim to obtain reimbursement for Covered Services.

SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION

Precertification Review

When required, Precertification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Member's benefit plan. Examples of these services include planned or elective Inpatient Admissions and selected Outpatient procedures. For groups located in the Personal Choice Network service area, Precertification review may be initiated by the Provider or the Member depending on whether the Provider is a Personal Choice Network Provider. For Member's located outside the Health Benefit Plan's Personal Choice Network who are accessing BlueCard Providers, the Member is responsible for initiating or requesting the Provider to initiate the Precertification review (excluding Inpatient Admissions). Where Precertification review is required, the Health Benefit Plan's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Necessity of the requested procedure setting (For example, Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Precertification review is not required for Emergency services and is not performed where an agreement with the Health Benefit Plan's local In-Network Provider does not require such review.

The following information provides more specific information of this Program's Precertification requirements.

- **Inpatient Pre-Admission Review**
 - **In-Network Inpatient Admissions**
In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Health Benefit Plan as to the Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this **General Information** section. An In-Network Hospital, Skilled Nursing Facility, or other Facility Provider in the Personal Choice Network will verify the Precertification at or before the time of admission. The Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard Program. The Health Benefit Plan will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Member's who reside in the Health Benefit Plan's local Personal Choice Network service area, the Health Benefit Plan will hold the Member harmless and the Member will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Providers in the Personal Choice Network which fail to conform to the pre-admission certification requirements unless:

- The Provider provides prior written notice that the admission will not be paid by the Health Benefit Plan; and
 - The Member acknowledges this fact in writing together with a request to be admitted which states that the Member will assume financial liability for such Facility Provider admission.
- Out-of-Network Inpatient Admissions
- For an Out-of-Network Inpatient Admission, the Member is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.
- To obtain Precertification, the Member is responsible to contact or have the admitting Physician or other Facility Provider contact the Health Benefit Plan prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Health Benefit Plan will notify the Member, admitting Physician and the Facility Provider of the determination. The Member is eligible for Inpatient benefits at the Out-of-Network level shown in the **Schedule of Covered Services** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this Benefit Booklet.
 - If such prior approval for a Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown below, will be deemed not to be Covered Services under this Program. Such Penalty, and any difference in what is covered by the Health Benefit Plan and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

If a Member elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Member will be financially liable for non-covered Inpatient charges.

- If Precertification is denied, the Member, the Physician or the Facility Provider may Appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Member, Physician, or Facility Provider will be so notified.

▪ Emergency Admission Review

– In-Network Admissions

It is the responsibility of the In-Network Provider to notify the Health Benefit Plan of the In-Network Emergency admission.

– Out-of-Network Provider Admissions

- Members are responsible for notifying the Health Benefit Plan of an Out-of-Network Provider Emergency admission within two business days of the admission, or as soon as reasonably possible, as determined by the Health Benefit Plan.
- Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Out-of-Network services. Such Penalty, as shown below, will be the sole responsibility of, and payable by, the Member.
- If the Member elects to remain hospitalized after the Health Benefit Plan and the attending Physician have determined that an Inpatient level of care is not Medically Necessary, the Member will be financially liable for non-covered Inpatient charges from the date of notification.

- Concurrent and Retrospective Review

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the Member and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

Retrospective/Post Service review:

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Health Benefit Plan not being notified of a Member's admission until after discharge or where medical charts are unavailable at the time of concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, the Health Benefit Plan also may determine coverage of certain procedures and other benefits available to Members through Prenotification as required by the Member's benefit plan, and discharge planning.

Pre-notification. Pre-notification is advance notification to the Health Benefit Plan of an Inpatient Admission or Outpatient service where no Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Members for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Members who may benefit from Case Management programs.

Discharge Planning. Discharge Planning is performed during an Inpatient Admission and is used to identify and coordinate a Member's needs and benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Health Benefit Plan's authorization of covered post-Hospital services and identifying and referring Members to Disease Management or Case Management benefits.

Selective Medical Review. In addition to the foregoing requirements, the Health Benefit Plan reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not subject to review as described above. In addition, the Health Benefit Plan reserves the right to waive medical review for certain Covered Services for certain Providers, if the Health Benefit Plan determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services. Coverage penalties are not applied to Members where required Selective Medical Review is not obtained by the Provider.

Other Precertification Requirements

Precertification is required by the Health Benefit Plan in advance for certain services. **To obtain a list of services that require Precertification, please log on to www.ibxpress.com or call the Customer Service telephone number that is listed on the Member's Identification Card.** When a Member plans to receive any of these listed procedures, the Health Benefit Plan will review the Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed on the Precertification requirements list, that are performed during an Emergency, as determined by the Health Benefit Plan, do not require Precertification. However, the Health Benefit Plan should be notified within two business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Health Benefit Plan.

- In-Network Care

In-Network Providers in the Personal Choice Network must contact the Health Benefit Plan to initiate Precertification. The Health Benefit Plan will verify the results of the Precertification with the Member and with the In-Network Provider. If the In-Network Provider is a BlueCard Provider, however, the Member must initiate Precertification (excluding Inpatient Admissions).

If such prior approval is not obtained and the Member undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, subject to a Penalty.

For In-Network Providers in the Personal Choice Network, the Health Benefit Plan will hold the Member harmless and the Member will not be financially responsible for this financial Penalty for the In-Network Provider's failure to comply with the Precertification requirements or determination, unless a Member elects to receive the treatment after review and written notification that the procedure is not covered as Medically Necessary. In which case benefits will not be provided and the Member will be financially liable for non-covered charges.

- Out-of-Network Care

For Out-of-Network Care and care provided by BlueCard Providers (excluding Inpatient Admissions), the Member is responsible to have the Provider performing the service contact the Health Benefit Plan to initiate Precertification. The Health Benefit Plan will verify the results of the Precertification with the Member and the Provider.

If such prior approval is not obtained and the Member undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as reflected below. Such Penalty, and any difference in what is covered by the Health Benefit Plan and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

Precertification Penalty:

If the Provider is a BlueCard® Provider of another Blue Plan (excluding Inpatient Admissions) or the Member uses an Out-of-Network Provider, the Member must obtain Precertification if required. The Member will be subject to a 20% reduction in benefits if Precertification is not obtained.

In addition to the Precertification requirements referenced above, the Member should contact the Health Benefit Plan for certain categories of treatment (listed below) so that the Member will know prior to receiving treatment whether it is a Covered Service. This applies to In-Network Providers in the Personal Choice Network and to Members (and their Providers) who elect to receive treatment provided by either BlueCard Providers or Out-of-Network Providers. Those categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic;
- Any procedure, treatment, drug or device that represents "emerging technology"; and
- Services that might be considered Experimental/Investigative.

The Member's Provider should be able to assist in determining whether a proposed treatment falls into one of these three categories. Also, the Health Benefit Plan encourages the Member's Provider to place the call for the Member.

For more information, please see the **Important Notices** section of this Benefit Booklet that pertain to Experimental/Investigative Services, Cosmetic services, Medically Necessary services and Emerging Technology.

Disease Management and Decision Support Programs

Disease Management and Decision Support programs help Members to be effective partners in their health care by providing information and support to Members with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Members with certain chronic diseases, intervening with specific information or support to follow Provider's treatment plan, and measuring clinical and other outcomes. Decision Support involves identifying Members who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their Physicians. Decision Support also includes the availability of general health information, personal health coaching, Provider information, or other programs to assist in health care decisions.

Disease Management interventions are designed to help Members manage their chronic condition in partnership with their Physician(s). Disease Management programs, when successful, can help such Members avoid long term complications, as well as relapses that would otherwise result in Hospital or Emergency room care. Disease Management programs also include outreach to Members to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the form of telephonic health coaching, print, audio library or videotape, or Internet formats.

The Health Benefit Plan will utilize medical information such as claims data to operate the Disease Management or Decision Support program, (For example, to identify Members with chronic disease, to predict which Members would most likely benefit from these services, and to communicate results to the Member's treating Physician(s)). The Health Benefit Plan will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Member in Disease Management or Decision Support programs is voluntary. A Member may continue in the Disease Management or Decision Support program until any of the following occurs:

- The Member notifies the Health Benefit Plan that they have declined participation; or
- The Health Benefit Plan determines that the program, or aspects of the program, will not continue.

Out-Of-Area Care for Dependent Students

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by the Personal Choice Network, the student may be eligible to receive Out-of-Network care at the In-Network level of benefits. Charges for treatment will be paid at the In-Network level of benefits when the Dependent student receives care from

Providers as described in the "BlueCard Program" subsection of the **General Information** section. However, treatment provided by an educational facility's infirmary for Urgent Care, (For example, may also be paid at the In-Network level of benefits, but the Health Benefit Plan should be notified within 48 hours of treatment to insure Covered Services are treated as In-Network Covered Services). Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under this Program.

UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process

A basic condition of IBC's, and its subsidiary QCC Insurance Company's ("the Health Benefit Plan") benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Necessary. To assist the Health Benefit Plan in making coverage determinations for requested health care services, the Health Benefit Plan uses established IBC Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Member's benefit plan is called utilization review.

It is not practical to verify Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by the Health Benefit Plan to be Medically Necessary and automatically approved based on the accepted Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an Emergency room which has been approved by the Health Benefit Plan based on the procedure meeting Emergency criteria and the severity of diagnosis reported (For example, rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Health Benefit Plan follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Health Benefit Plan's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Health Benefit Plan may deny coverage for a procedure based on Medical Necessity. The evidence-based clinical protocols evaluate the Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration the individual Member's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for

specific conditions. Should a procedure be denied for coverage based on lack of Medical Necessity, a letter is sent to the requesting Provider and Member in accordance with applicable law.

The Health Benefit Plan's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to the Health Benefit Plan's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external Physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Health Benefit Plan does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

Clinical Criteria, Guidelines and Resources

The following guidelines, clinical criteria and other resources are used to help make Medical Necessity coverage decisions:

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Health Benefit Plan in determining Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Necessity of coverage based on a Member's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Health Benefit Plan's plan determinations for similar medical issues and requests, and reduces practice variation among the Health Benefit Plan's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following:

- Some elective surgeries-settings for Inpatient and Outpatient procedures (For example, hysterectomy and sinus Surgery);
- Inpatient hospitalizations;
- Inpatient Rehabilitation;
- Home Health;
- Durable Medical Equipment;
- Skilled Nursing Facility.

Centers for Medicare and Medicaid Services (CMS) Guidelines: A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare Members.

IBC Medical Policies: IBC maintains an internally developed set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which IBC's Medical Polices are applied include, but are not limited to:

- Ambulance;
- Infusion;
- Speech Therapy;
- Occupational Therapy;
- Durable Medical Equipment;
- Review of potential cosmetic procedures.

IBC (and QCC) Internally Developed Guidelines: A set of guidelines developed specifically by IBC (and QCC), as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting IBC Medical Policies for coverage.

Delegation of Utilization Review Activities And Criteria

In certain instances, the Health Benefit Plan has delegated certain utilization review activities, including Precertification review, concurrent review, and Case Management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as mental health/psychiatric care and Alcohol and Drug Abuse or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Health Benefit Plan's approval.

Utilization Review and Criteria for Mental Health/Psychiatric Care and Alcohol and Drug Abuse Services

Utilization Review activities for mental health/psychiatric care and Alcohol and Drug Abuse services have been delegated by IBC (and QCC) to a behavioral health management company, which administers the mental health/psychiatric care and Alcohol and Drug Abuse benefits for the majority of the Health Benefit Plan's Members.

COORDINATION OF BENEFITS

Coordination of Benefits

This Program's Coordination of Benefits (COB) provision is designed to conserve funds associated with health care.

- Definitions

In addition to the Definitions of this Program for purposes of this provision only:

"Plan" shall mean any group arrangement providing health care benefits or Covered Services through:

- Individual, group, (except hospital indemnity plans), blanket (except student accident) or franchise insurance coverage;
- The Plan, health maintenance organization and other prepayment coverage;
- Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
- Coverage under any tax supported or government program to the extent permitted by law.

- Determination of Benefits

COB applies when an Employee has health care coverage under any other group health care plan (Plan) for services covered under this Program, or when the Employee has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between the Health Benefit Plan and the other Plan in order to avoid duplication of benefits.

Benefits under this Program will be provided in full when the Health Benefit Plan is primary, that is, when the Health Benefit Plan determines benefits first. If another Plan is primary, the Health Benefit Plan will provide benefits as described below.

When an Employee has group health care coverage under this Program and another Plan, the following will apply to determine which coverage is primary:

- If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
- If the other Plan includes rules for coordinating benefits:
 - The Plan covering the patient other than as a Dependent shall be primary.
 - The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary.
 - Except as provided in the following paragraph, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
 - ❖ First, the Plan covering the child as a Dependent of the parent with custody;
 - ❖ Then, the Plan of the spouse of the parent with custody of the child;
 - ❖ Finally, the Plan of the parent not having custody of the child.
 - When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.
 - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in the paragraph that begins "The Plan covering the patient as a Dependent...".
- The Plan covering the patient as an Employee who is neither laid off nor retired (or as that Employee's Dependent) is primary to a Plan which covers that patient as a laid off or retired Employee (or as that Employee's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

▪ Effect on Benefits

When the Health Benefit Plan's Plan is secondary, the benefits under this Program will be reduced so that the Health Benefit Plan will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Program and the total Covered Services provided to the Employee. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made therefore. In no event will the Health Benefit Plan payment exceed the amount that would have been payable under this Program if the Health Benefit Plan were primary.

When the benefits are reduced under the primary Plan because an Employee does not comply with the Plan provision, or does not maximize benefits available under the primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are Penalties and increased Coinsurance related to Precertification of admissions and services, In-Network Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. The Health Benefit Plan has the right to decide which facts are needed. The Health Benefit Plan may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Health Benefit Plan deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Health Benefit Plan such information as may be necessary to implement this provision. The Health Benefit Plan, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Program shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Health Benefit Plan is furnished with information relative to such other Plans.

▪ **Right of Recovery**

Whenever payments which should have been made under this Program in accordance with this provision have been made under any other Plan, the Health Benefit Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Program and, to the extent of such payments, the Health Benefit Plan shall be fully discharged from liability under this Program.

Whenever payments have been made by the Health Benefit Plan in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Health Benefit Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Health Benefit Plan shall determine:

- The person the Health Benefit Plan has paid or for whom they have paid;
- Insurance companies; or
- Any other organizations.

The Member, on the Member's own behalf and on behalf of the Member's Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to the Health Benefit Plan.

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The Health Benefit Plan has a right to full reimbursement.

Lien

By accepting benefits for Covered Services from the Health Benefit Plan, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan is reimbursed in full.

Constructive Trust

If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Health Benefit Plan to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.

- The Health Benefit Plan is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing. The recovery rights of the Health Benefit Plan will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative – or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
- Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

CLAIM PROCEDURES

How To File A Claim

The Member is never required to file a claim when Covered Services are provided by In-Network Providers. When the Member receives care from an Out-of-Network Provider, the Member will need to file a claim to receive benefits. If the Member does not have a claim form, the Member should call the Health Benefit Plan's Member Services Department at the number listed on the Member's Identification Card, and a claim form will be sent to the Member. The Member should fill out the claim form and return it with their itemized bills to the Health Benefit Plan at the address listed on the claim form no later than 20 days after completion of the Covered Services. The claim should include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, the Member's benefits will not be reduced, but in no event will the Health Benefit Plan be required to accept the claim more than 12 months after the end of the Benefit Period in which the Covered Services are rendered.

Release Of Information

Each Member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Program may furnish to the Health Benefit Plan, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Health Benefit Plan may furnish similar information to other entities providing similar benefits at their request.

The Health Benefit Plan may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Health Benefit Plan needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Member who is unable to provide it, the Health Benefit Plan will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Member.

Limitation Of Actions

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the date Covered Services are rendered.

Claim Forms

The Health Benefit Plan will furnish to the Member or to the Group, for delivery to the Member, such claim forms as are required for filing proof of loss for Covered Services provided by Out-of-Network Providers.

Timely Filing

The Health Benefit Plan will not be liable under this Program unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within 90 days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than 12 months after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by In-Network Providers.

Time of Payment of Claims

Claim payments for benefits payable under this Program will be processed immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all benefits for loss for which this Program provides periodic benefits will be paid not more than 30 days after receipt of proof of loss and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

If any indemnity of this Program shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the Health Benefit Plan may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by the Health Benefit Plan to be equitably entitled thereto. Any payment made by the Health Benefit Plan in good faith pursuant to this provision shall fully discharge the Health Benefit Plan to the extent of such payment.

Physical Examinations and Autopsy

The Health Benefit Plan at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under this Program; and the Health Benefit Plan shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this Program (For example, obtaining Precertification, use of In-Network Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan may on a selective basis, waive certain procedural requirements of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Health Benefit Plan shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Health Benefit Plan nor the Providers in the Health Benefit Plan's PPO network shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances as recognized in the community, and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot; or
- Civil insurrection.

COMPLAINT AND APPEAL PROCESS

Member Complaint Process

The Health Benefit Plan has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on their Identification Card or write to the Health Benefit Plan at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Health Benefit Plan is unable to immediately resolve the Member Complaint, it will be investigated, and the Member will receive a response in writing within 30 days.

Member Appeal Process

Filing an Appeal. The Health Benefit Plan maintains procedures for the resolution of Member Appeals. Member Appeals may be filed within 180 days of the receipt of a decision from the Health Benefit Plan stating an adverse benefit determination. An Appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Health Benefit Plan by following the procedures described here. (In order to authorize someone else to be the Member's representative for the Appeal, the Member must complete a valid authorization form. The Member must contact the Health Benefit Plan as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an Appeal by calling or writing to the Health Benefit Plan, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820

Toll Free Phone: 1-888-671-5276 (TTY: 711)
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 215-988-6558

Changes in Member Appeals Process. Please note that the Member Appeals process may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member Appeals process, or to reflect other decisions regarding the administration of Member Appeals process for this Program.

Copies of the Member Appeals Process Descriptions. Descriptions of the timeframes and procedures for the Member Appeals process maintained by the Health Benefit Plan are available from the following sources:

On the Internet at the Website for the Member's Health Plan. Copies are available there at any time. To see samples of the Member Appeals process, search for "member appeals" in the general search engine. To review a description of the Member Appeals process for the Member's health plan, the Member must log in with the Member's personalized password.

Customer Service. To obtain a description of the Member Appeals process for the Member's health plan, call Customer Service at the telephone number listed on the Member's Identification Card. Customer Service will mail the Member a copy of the description.

When an Appeal is Filed. As part of the Member Appeal process, a description is provided for the type of Member Appeal that has been filed. The description is sent with the acknowledgment letter for the Member Appeal.

IMPORTANT DEFINITIONS

The terms below have the following meaning when describing the benefits in this Benefit Booklet. They will be helpful to you (the Member) in fully understanding your benefits.

Accidental Injury

Injury to the body that is solely caused by an accident, and not by any other causes.

Accredited Educational Institution

A publicly or privately operated academic institution of higher learning which:

- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
 - A diploma;
 - A degree; or
 - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
 - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to Colleges and Universities; and Technical or specialized schools.

Acupuncture

A therapeutic and/or preventive medical procedure performed by the insertion of one or more specially manufactured solid metallic needles into a specific location(s) on the body. The intent is to stimulate Acupuncture points, with or without subsequent manual manipulation.

Acupuncture has been used to induce anesthesia, relieve pain, alleviate withdrawal symptoms of addiction, and treat asthma and other disorders.

Alcohol Or Drug Abuse And Dependency

Any use of alcohol or other drugs which produces a pattern of pathological use that:

- Causes impairment in the way people relate to others; or
- Causes impairment in the way people function in their jobs or careers; or
- Produces a dependency that makes a person physically ill, when the alcohol or drug is taken away.

Alternative Therapies/Complementary Medicine

Complementary and alternative medicine, is defined as a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine based on recognition by the National Institutes of Health.

Ambulatory Surgical Facility

A facility licensed by the Pennsylvania Department of Health, which provides specialty or multispecialty Outpatient surgical treatment or procedure that is not located on the premises of a Hospital.

It is a Facility Provider which:

- Has an organized staff of Physicians;
- Is licensed as required; and
- Has been approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- Has been approved by the Accreditation Association for Ambulatory Health Care, Inc.; or
- Has been approved by the Health Benefit Plan.

It is also a Facility Provider which:

- Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- Provides treatment, by or under the supervision of Physicians and nursing services, whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Ancillary Service Provider

An individual or entity that provides Covered Services, supplies or equipment such as, but not limited to:

- Infusion Therapy Services;
- Durable Medical Equipment; and
- Ambulance services.

Anesthesia

The process of giving the Member an approved drug or agent, in order to:

- Cause the Member's muscles to relax;
- Cause the Member to lose feeling; or
- Cause the Member to lose consciousness.

Appeal

A request by a Member, or the Member's representative or Provider, acting on the Member's behalf upon written consent, to change a previous decision made by the Health Benefit Plan.

- **Administrative Appeal:** An Appeal by or on behalf of a Member that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative Appeal may present issues related to Medical Necessity, but these are not the primary issues that affect the outcome of the Appeal.
- **Medical Necessity Appeal:** A request for the Health Benefit Plan to change its decision, based primarily on Medical Necessity, to deny or limit the provision of a Covered Service.
- **Expedited Appeal:** A faster review of a Medical Necessity Appeal, conducted when the Health Benefit Plan determines that a delay in decision making would seriously jeopardize the Member's life, health, or ability to regain maximum function.

Applicant And Employee/Member

You, the Employee who applies for coverage under the Program.

Application And Application Card

The request of the Applicant for coverage:

- Either written or via electronic transfer; and
- Set forth in a format approved by the Health Benefit Plan.

Attention Deficit Disorder

A disease that makes a person have a hard time paying attention; be too impulsive; and be overly active.

Authorized Generics

Brand Name Drugs that are marketed without the brand name on its label. An Authorized Generic may be marketed by the Brand Name Drug company, or another company with the brand company's permission. Unlike a standard Generic Drug, the Authorized Generic is not approved by the Food and Drug Administration (FDA) abbreviated new drug application process (ANDA). For cost sharing purposes Authorized Generics are treated as Brand Name Drugs.

Autism Service Provider

A person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either:

- Licensed or certified in this Commonwealth; or
- Enrolled in the Commonwealth's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavioral Specialist.

Autism Spectrum Disorders (ASD)

Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor.

Autism Spectrum Disorders Treatment Plan (ASD Treatment Plan)

A plan for the treatment of Autism Spectrum Disorders:

- Developed by: A licensed Physician or licensed Psychologist who is a Professional Provider; and
- Based on: A comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

Behavioral Specialist

An individual with appropriate certification or licensure by the applicable state, who designs, implements or evaluates a behavior modification intervention component of an ASD (Autism Spectrum Disorder) Treatment Plan, through Applied Behavioral Analysis which includes:

- Skill acquisition and reduction of problematic behavior;
- Improve function and/or behavior significantly; or
- Prevent loss of attained skill or function.

Benefit Period

The specified period of time as shown in the **Schedule of Covered Services** within which the Member has to use Covered Services in order to be eligible for payment by their Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to the Member.

Birth Center

A Facility Provider approved by the Health Benefit Plan which:

- Is primarily organized and staffed to provide maternity care;
- Is where a woman can go to receive maternity care and give birth;
- Is licensed as required in the state where it is situated; and
- Is under the supervision of a Physician or a licensed certified nurse midwife.

BlueCard Program

A program that allows a Member travelling or living outside of their plan's area to receive coverage for services at an "In-Network" benefit level if the Member receives services from Blue Cross Blue Shield providers that participate in the BlueCard Program.

BlueCard Provider

A Provider that participates in the BlueCard Program as an In-Network Provider.

Care Coordinator Fee

A fixed amount paid by a /Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

Case Management

Comprehensive Case Management programs serve Members who have been diagnosed with an illness or injury that is complex, catastrophic, or chronic.

The objectives of Case Management are to:

- Make it easier for Members to get the service and care they need in an efficient way;
- Link the Member with appropriate health care or support services;
- Assist Providers in coordinating prescribed services;
- Monitor the quality of services delivered; and
- Improve Members' health outcomes.

Case Management supports Members and Providers by:

- Locating services;
- Coordinating services; and/or
- Evaluating services.

These steps are taken, across various levels and sites of care, for a Member who has been diagnosed with a complex, catastrophic or chronic illness and/or injury.

Certified Registered Nurse

Any one of the following types of nurses who are certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing:

- A certified registered nurse anesthetist;
- A certified community health nurse;
- A certified registered nurse practitioner;
- A certified psychiatric mental health nurse; or
- A certified entrestomal therapy nurse;
- A certified clinical nurse specialist.

This excludes any registered professional nurses employed by:

- A health care facility; or
- An anesthesiology group.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation is a medically prescribed, multidisciplinary approach that consists of tasks that:

- Establish new ways for a person to compensate for brain function that has been lost due to injury, trauma, stroke, or encephalopathy; or
- Reinforce or re-establish previously learned patterns of behavior.

It consists of a variety of therapy modalities which lessen and ease problems caused by deficits in:

- Attention;
- Visual processing;
- Language;
- Memory;
- Reasoning; and
- Problem solving.

Cognitive rehabilitation is performed by any of the following professionals, using a team approach:

- A Physician;
- A neuropsychologist;
- A Psychologist; as well as, a physical, occupational or speech therapist.

Coinsurance

A type of cost-sharing in which the Member assumes a percentage of the Covered Expense for Covered Services (such as 20%). The Coinsurance percentage is listed in the ***Schedule of Covered Services***.

It is the amount that the Member is obliged to pay for covered medical services, after the Member has satisfied any Copayment(s) or Deductible(s) required by this Program.

Compendia

Compendia are reference documents used by the Health Benefit Plan to determine if a prescription drug should be covered. Compendia provide:

- Summaries of how drugs work;
- Information about which drugs are recommended to treat specific diseases; and
- The appropriate dosing schedule for each drug.

Over the years, some Compendia have merged with other publications. The Health Benefit Plan only reviews current Compendia when making coverage decisions.

Complaint

Any expression of dissatisfaction, verbal or written, by a Member.

Conditions For Departments (for Qualifying Clinical Trials)

The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
- Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

Consumable Medical Supply

Non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

Copayment

A type of cost-sharing in which the Member pays a flat dollar amount each time a Covered Service is provided (such as a \$10 or \$15 Copayment per office visit). Copayments, if any, are identified in the ***Schedule of Covered Services***.

Covered Expense

Refers to the basis on which a Member's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- For Covered Services provided by a Facility Provider, the term "Covered Expense" means the following:
 - For Covered Services provided by an In-Network Facility Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Health Benefit Plan.
 - For Covered Services provided by an In-Network Facility or BlueCard Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Health Benefit Plan or the BlueCard Provider.
 - For Covered Services provided by an Out-of-Network Facility Provider, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Facility Provider's charges for Covered Services.
 - For Covered Services provided by an Out-of-Network Facility Provider, "Covered Expense" for Inpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by the applicable Health Benefit Plan's proprietary fee schedule for the closest analogous Covered Service.
- For Covered Services provided by a Professional Provider, "Covered Expense" means the following:
 - For Covered Services by an In-Network Professional Provider or BlueCard Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Health Benefit Plan, or the BlueCard Provider;
 - For an Out-of-Network Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or of the Provider's charges for Covered

Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Professional Provider's charges for Covered Services.

- For Covered Services provided by an Ancillary Service Provider, "Covered Expense" means the following:
 - For Covered Services provided by an In-Network Ancillary Service Provider or BlueCard Provider "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Health Benefit Plan or BlueCard Provider.
 - For Covered Services provided by an Out-of-Network Ancillary Service Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Out-of-Network Ancillary Service Provider's charges for Covered Services.
- Nothing in this section shall be construed to mean that the Health Benefit Plan would provide coverage for services other than Covered Services.

Covered Service

A service or supply specified in this Benefit Booklet for which benefits will be provided by the Health Benefit Plan.

Custodial Care (Domiciliary Care)

Care provided primarily for Maintenance of the patient or care which is designed essentially:

- To assist the patient in meeting his activities of daily living; and
- Which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Custodial Care includes help in tasks which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

Such tasks include, but are not limited to:

- Walking;
- Bathing;
- Dressing;
- Feeding;
- Preparation of special diets; and
- Supervision over self-administration of medications.

Day Rehabilitation Program

A level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week.

The Member returns home:

- Each evening; and
- For the entire weekend.

Therapies provided may include a combination of therapies, such as:

- Physical Therapy;
- Occupational Therapy; and
- Speech Therapy.

Other medical services such as:

- Nursing services;
- Psychological therapy; and
- Case Management services.

Day Rehabilitation sessions also include a combination of:

- One-to-one therapy; and
- Group therapy.

Decision Support

Services that help Members make well-informed decisions about Health care and support their ability to follow their Provider's treatment plan. Some examples of support services are:

- Major treatment choices; and
- Every day health choices.

Deductible

A specified amount of Covered Expense for the Covered Services that is Incurred, by the Member, before the Health Benefit Plan will assume any liability.

- A specific dollar amount that the Member's Health Benefit Plan may require that the Member pay out-of-pocket each Benefit Period, before the Program begins to make payments for claims.

Detoxification

The process by which a person who is alcohol or drug intoxicated, or alcohol or drug dependent, is assisted under the following circumstances:

- In a state licensed Facility Provider; or
- In the case of opiates, by an appropriately licensed behavioral health provider, in an ambulatory (Outpatient) setting.

This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, any or each of the following problems:

- The intoxicating alcohol or drug;
- Alcohol or drug dependency factors; or
- Alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

Disease Management

An approved program designed to identify and help people, who have a particular chronic disease, to stay as healthy as possible.

- Disease Management programs use a population-based approach to:
 - Identify Members who have or are at risk for a particular chronic medical condition;
 - Intervene with specific programs of care; and
 - Measure and improve outcomes.

- Disease Management programs use evidence-based guidelines to:
 - Educate and support Members and Providers;
 - Matching interventions to Members with greatest opportunity for improved clinical or functional outcomes.

- To assist Members with chronic disease(s), Disease Management programs may employ:
 - Education;
 - Provider feedback and support statistics;
 - Compliance monitoring and reporting; and/or
 - Preventive medicine.

- Disease Management interventions are intended to both:
 - Improve delivery of services in various active stages of the disease process; as well as to reduce/prevent relapse or acute exacerbation of the condition.

Durable Medical Equipment (DME)

Equipment that meets the following criteria:

- It is durable. (That is, an item that can withstand repeated use.)
- It is medical equipment. (That is, equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury.)
- It is generally not useful to a person without an illness or injury.
- It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to:

- | | |
|----------------------|---------------------------|
| ▪ Diabetic supplies; | ▪ Home oxygen equipment; |
| ▪ Canes; | ▪ Hospital beds; |
| ▪ Crutches; | ▪ Traction equipment; and |
| ▪ Walkers; | ▪ Wheelchairs. |
| ▪ Commode chairs; | |

Effective Date

The date on which coverage for a Member begins under the Program. All coverage begins at 12:01 a.m. on the date reflected on the records of the Health Benefit Plan.

Emergency

The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the Member's health, or in the case of a pregnant Member, the health of the unborn child, in jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Care

Covered Services and supplies provided to a Member in, or for, an Emergency:

- By a Hospital or Facility Provider and/or Professional Provider; and
- On an Outpatient basis; and
- In a Hospital Emergency Room or Outpatient Emergency Facility.

Employee

An individual of the Group contracting with the Health Benefit Plan and:

- Who meets the eligibility requirements for enrollment; and
- Who, at enrollment, is specified as meeting the eligibility requirements; and
- In whose name the Identification Card is issued.

Equipment For Safety

Equipment used to keep people safe.

These are:

- Items that are not primarily used for the diagnosis, care or treatment of disease or injury.
- Items which are primarily used to prevent injury or provide a safe surrounding.

Examples include:

- Restraints;
- Safety straps;
- Safety enclosures; and
- Car seats.

Essential Health Benefits

A set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. Essential health benefits must include items and services within at least the following 10 categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription Drugs;
- Rehabilitative and habilitative services And devices;
- Laboratory services;
- Preventive and wellness services and Chronic disease management; and
- Pediatric services, including oral and vision care.

Experimental/Investigative Services

A drug, biological product, device, medical treatment or procedure, or diagnostic test which meets any of the following criteria:

- Is the subject of: Ongoing clinical trials;
- Is the research, experimental, study or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

Any drug, biological product, device, medical treatment or procedure, or diagnostic test is not considered Experimental/Investigative if it meets all of the criteria listed below:

- When required, the drug, biological product, device, medical treatment or procedure, or diagnostic test must have final approval from the appropriate governmental regulatory bodies (For example, FDA).
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes (That is, the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure or diagnostic test is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Any approval granted as an interim step in the FDA regulatory process (For example, An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of a drug or biological product (For example, infusible agent) for another diagnosis or condition shall require that one or more of the established reference Compendia identified in the Health Benefit Plan policies recognize the usage as appropriate medical treatment.

Facility Provider

An institution or entity licensed, where required, to provide care.

Such facilities include:

- Ambulatory Surgical Facility;
- Birth Center;
- Free Standing Dialysis Facility;
- Free Standing Ambulatory Care Facility;
- Home Health Care Agency;
- Hospice;
- Hospital;
- Non-Hospital Facility;
- Psychiatric Hospital;
- Rehabilitation Hospital;
- Residential Treatment Facility;
- Short Procedure Unit;
- Skilled Nursing Facility.

Family Coverage

Coverage purchased for the Member and one or more of the Member's Dependents.

Free Standing Ambulatory Care Facility

A Facility Provider, other than a Hospital, that provides treatment or services on an Outpatient or partial basis.

In addition, the facility:

- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician.
- Is licensed by the state in which it is located and be accredited by the appropriate regulatory body.

Free Standing Dialysis Facility

A Facility Provider that provides dialysis services for people who have serious kidney disease.

In addition, the facility:

- Is primarily engaged in providing dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.
- Is licensed or approved by the appropriate governmental agency; and
- Is approved by the Health Benefit Plan.

Group or (Enrolled Group)

A group of Employees which has been accepted by the Health Benefit Plan, consisting of all those Applicants whose charges are remitted by the Applicant's Agent together with all the Employees, listed on the Application Cards or amendments thereof, who have been accepted by the Health Benefit Plan.

Hearing Aid

A Prosthetic Device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of:

- A microphone to pick up sound;
- An amplifier to increase the sound;
- A receiver to transmit the sound to the ear; and
- A battery for power.

A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles:

- Behind-The-Ear;
- In-The-Ear;
- In-The-Canal;
- Completely-In-The-Canal; or
- Implantable (Can Be Partial or Complete).

A Hearing Aid is not a cochlear implant.

Home

For purposes of the Home Health Care and Homebound Covered Services only, this is the place where the Member lives.

This place may be:

- A private residence/domicile;
- An assisted living facility;
- A long-term care facility; or
- A Skilled Nursing Facility at a custodial level of care.

Homebound

Being unable to safely leave Home due to severe restrictions on the Member's mobility.

A person can be considered Homebound when: Leaving Home would do the following:

- Involve a considerable effort by the Member; and
- Leave the Member unable to use transportation, without another's assistance.

The following individuals will NOT automatically be considered Homebound: But must meet both requirements shown above:

- A child;
- An unlicensed driver; or
- An individual who cannot drive.

Home Health Care Provider

A Facility Provider, approved by the Health Benefit Plan, that is engaged in providing, either directly or through an arrangement, health care services to Members:

- On an intermittent basis in the Member's Home.
- In accordance with an approved home health care Plan Of Treatment.

Hospice

A Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals.

The Hospice must be:

- Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and
- Appropriately licensed in the state where it located.

Hospital

An approved facility that provides Inpatient, as well as Outpatient Care, and that meet the requirements listed below.

The term Hospital specifically refers to a short-term, acute care, general Hospital which has been approved by The Joint Commission on Accreditation of Healthcare Organizations; and/or by the American Osteopathic Hospital Association or by the Health Benefit Plan, and which meets the following requirements:

- Is a duly licensed institution;
- Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- Has organized departments of medicine;
- Provides 24-hour nursing service by or under the supervision of Registered Nurses;
- Is not, other than incidentally, any of the following:
 - Skilled Nursing Facility;
 - Nursing home;
 - School;
 - Custodial Care home;
 - Health resort;
 - Spa or sanitarium;
 - Place for rest;
 - Place for aged;
 - Place for treatment of Mental Illness;
 - Place for treatment of Alcohol or Drug Abuse;
 - Place for provision of rehabilitation care;
 - Place for treatment of pulmonary tuberculosis;
 - Place for provision of Hospice care.

Hospital-Based Provider

A Physician who provides Medically Necessary services in a Hospital or other In-Network Facility Provider and meets the requirements listed below:

- The Medically Necessary services must be supplemental to the primary care being provided in the Hospital or In-Network Facility Provider;
- The Medically Necessary services must be those for which the Member has limited or no control of the selection of such Physician;
- Hospital-Based Providers include Physicians in the specialties of:
 - Radiology;
 - Anesthesiology;
 - Pathology; and/or
 - Other specialties, as determined by the Health Benefit Plan.

When these Physicians provide services other than in the Hospital or other In-Network Facility, they are not considered Hospital-Based Providers.

Identification Card (ID Card)

The currently effective card issued to the Member by the Health Benefit Plan which must be presented when a Covered Service is requested.

Immediate Family

The Employee's:

- Spouse;
- Parent;
- Child, stepchild;
- Brother, sister;
- Mother-in-law, father-in-law;
- Sister-in-law, brother-in-law;
- Daughter-in-law, son-in-law.

Incurred

A charge shall be considered Incurred (acquired) on the date a Member receives the service or supply for which the charge is made.

Independent Clinical Laboratory

A laboratory that performs clinical pathology procedure and that is not affiliated or associated with a:

- Hospital;
- Physician; or
- Facility Provider.

In-Network Ancillary Service Provider

An Ancillary Service Provider that is:

- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Facility Provider

A Facility Provider that is:

- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Professional Provider

A Professional Provider that is:

- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Provider

A Facility Provider, Professional Provider or Ancillary Service Provider that is:

- A member of the Personal Choice Network or is a BlueCard Provider; and
- Authorized to perform specific "in-network" Covered Services at the In-Network level of benefits.

Inpatient Admission (Inpatient)

The actual entry of a Member, who is to receive Inpatient services as a registered bed patient, and for whom a room and board charge is made, into any of the following:

- Hospital;
- Extended care facility; or
- Facility Provider.

The Inpatient Admission shall continue until such time as the Member is actually discharged from the facility.

Inpatient Care For Alcohol Or Drug Abuse And Dependency

The provision of medical, nursing, counseling or therapeutic services 24 hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

Intensive Outpatient Program

A planned, structured program that coordinates and uses the services of various health professionals, to treat patients in crisis who suffer from:

- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency.

Intensive Outpatient Program treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until they are able to transition to less intensive Outpatient treatment, as required.

Licensed Clinical Social Worker

A social worker who:

- Has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree; and
- Is licensed by the appropriate state authority.

Licensed Practical Nurse (LPN)

A nurse who:

- Has graduated from a formal practical or nursing education program; and
- Is licensed by the appropriate state authority.

Life-Threatening Disease Or Condition (for Qualifying Clinical Trials)

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limiting Age For Dependents

The age at which a child is no longer eligible as a Dependent under the Member's coverage. The Limiting Age for covered children is shown in the **General Information** section.

Maintenance

A continuation of the Member's care and management when:

- The maximum therapeutic value of a Medically Necessary treatment plan has been achieved;
- No additional functional improvement is apparent or expected to occur;
- The provision of Covered Services for a condition ceases to be of therapeutic value; and
- It is no longer Medically Necessary.

This includes Maintenance services that seek to:

- Prevent disease;
- Promote health; and
- Prolong and enhance the quality of life.

Managed Care Organization (MCO)

A generic term for any organization that manages and controls medical service.

It includes:

- HMOs;
- PPOs;
- Managed indemnity insurance programs; and
- Managed Blue Cross or Blue Shield programs.

Master's Prepared Therapist

A therapist who:

- Holds a Master's Degree in an acceptable human services-related field of study;
- Is licensed as a therapist at an independent practice level; and
- Is licensed by the appropriate state authority to provide therapeutic services for the treatment of Mental Health/Psychiatric Services (including treatment of Serious Mental Illness).

Maximum

A limit on the amount of Covered Services that a Member may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Members for the Covered Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Health Benefit Plan to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

- Benefit Maximum - the greatest amount of a specific Covered Service that a Member may receive.
- Lifetime Maximum - the greatest amount of Covered Services that a Member may receive in the Member's lifetime.

Medical Care

Services rendered by a Professional Provider for the treatment of an illness or injury. These are services that must be rendered within the scope of their license.

Medical Foods

Liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

Medically Necessary (Medical Necessity)

Shall mean:

- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of:
 - Preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:
 - In accordance with generally accepted standards of medical practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
 - Not primarily for the convenience of the patient, Physician, or other health care provider; and
 - Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on:
 - Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations; and
 - The views of Physicians practicing in relevant clinical areas; and
 - Any other relevant factors.

Medical Policy

Medical Policy is used to determine whether Covered Services are Medically Necessary.

Medical Policy is developed based on various sources including, but not limited to:

- Peer-reviewed scientific literature published in journals and textbooks; and
- Guidelines put forth by governmental agencies; and
- Respected professional organizations; and
- Recommendations of experts in the relevant medical specialty.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Allowable Payment for Facilities

The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

Medicare Ancillary Allowable Payment

The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Service Provider.

Medicare Professional Allowable Payment

The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule – Pennsylvania Locality 01.

Member

An enrolled Employee or their Eligible Dependent(s) who have satisfied the specifications of the **General Information** section.

A Member does NOT mean any person who is eligible for Medicare, except as specifically stated in this Benefit Booklet.

Mental Illness

Any of various conditions, wherein mental treatment is provided by a qualified mental health Provider.

- These various conditions must be categorized as mental disorders by the most current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM).
- For purposes of this Program, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness or Autism Spectrum Disorders.
- The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

Methadone Treatment

Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement

An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Non-Hospital Facility

A Facility Provider, licensed by the Department of Health for the care or treatment of Members diagnosed with Alcohol Or Drug Abuse And Dependency. This does NOT include transitional living facilities.

Non-Hospital Facilities, shall include, but not be limited to the following, for Partial Hospitalization programs:

- Residential Treatment Facilities; and
- Free Standing Ambulatory Care Facilities.

Non-Hospital Residential Treatment

The provision of medical, nursing, counseling, or therapeutic services to Members diagnosed with Alcohol Or Drug Abuse And Dependency:

- In a residential environment;
- According to individualized treatment plans.

Non-Preferred Drug

These drugs generally have one or more generic alternatives or preferred brand options within the same drug class.

Nutritional Formula

Liquid nutritional products which are formulated to supplement or replace normal food products.

Out-of-Network Ancillary Service Provider

An Ancillary Service Provider that is NOT a member of the Personal Choice Network or is NOT a BlueCard Provider.

Out-of-Network Facility Provider

A Facility Provider that is NOT a member of the Personal Choice Network or is NOT a BlueCard Provider.

Out-of-Network Professional Provider

A Professional Provider who is NOT a:

- Member of the Personal Choice Network; or
- BlueCard Provider.

Out-of-Network Provider

A Facility Provider, Professional Provider or Ancillary Service Provider that is NOT a:

- Member of the Personal Choice Network; or
- BlueCard Provider.

Out-of-Pocket Limit

A specified dollar amount of Covered Expense Incurred by the Member for Covered Services in a Benefit Period. The Out-of-Pocket Limits are calculated as follows:

- The In-Network Out-of-Pocket Limit expense includes Copayments, Coinsurance and Deductibles, if applicable. The amount of the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit will only include expenses for Essential Health Benefits. When the In-Network Out-of-Pocket Limit is reached, the level of benefits is increased as set forth in the ***Schedule of Covered Services***.
- The Out-of-Network Out-of-Pocket Limit expense includes Coinsurance but does not include any Copayments, Deductibles, Penalties, or amounts that exceed the Health Benefit Plan's payment (see the definition for "Covered Expense" for more details). When the Out-of-Network Out-of-Pocket Limit is reached, the level of benefits is increased, as specified in the ***Schedule of Covered Services***.

Outpatient Care (or Outpatient)

Medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other Inpatient Facility.

Outpatient Diabetic Education Program

An Outpatient Diabetic Education Program, provided by an In-Network Provider that has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

Partial Hospitalization

Medical, nursing, counseling or therapeutic services that are:

- Provided on a planned and regularly scheduled basis in a Hospital or Facility Provider; and
- Designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient Program or Outpatient office visit) but who does not require Inpatient confinement.

Penalty

A type of cost-sharing in which the Member is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified and explained in detail in the **General Information** section.

Personal Choice Network

The network of Providers with whom the Health Benefit Plan has contractual arrangements.

Pervasive Developmental Disorders (PDD)

Disorders characterized by severe and pervasive impairment in several areas of development:

- Reciprocal social interaction skills;
- Communication skills; or
- The presence of stereotyped behavior, interests and activities.

Examples are:

- Asperger's syndrome; and
- Childhood disintegrative disorder.

Physician

A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

Plan Of Treatment

A plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should include goals and duration of treatment, and be limited in scope and extent to that care which is Medically Necessary for the Member's diagnosis and condition.

Precertification (or Precertify)

Prior assessment by the Health Benefit Plan or a designated agent that proposed services, such as hospitalization, are Medically Necessary for a Member and covered by this Program.

Payment for services depends on whether the Member and the category of service are covered under this Program.

Preferred Brand

These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

Preferred Provider Organization (PPO)

A type of managed care plan that:

- Offers the freedom to choose a Physician like a traditional health care plan; and
- Provides the Physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization).

In a PPO, an individual is:

- Not required to select a primary care Physician to coordinate care; and
- Not required to obtain referrals to see specialists.

Prenotification (Prenotify)

The requirement that a Member provide prior notice to the Health Benefit Plan that proposed services, such as maternity care, are scheduled to be performed.

- No Penalty will be applied for failure to comply with this requirement.
- Payment for services depends on whether the Member and the category of service are covered under this Program.
- To Prenotify, the Member should call the telephone number on the ID card, prior to obtaining the proposed service.

Preventive Care

Means:

- Evidence-based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the Member;
- Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
- Evidence-informed preventive care and screenings for Members who are infants, children, and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Evidence-informed preventive care and screenings for female Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Any other evidence-based or evidence-informed items as determined by the federal and/or state law.

Examples of Preventive Care include, but are not limited to:

- Routine physical examinations, including related laboratory tests and X-rays;
- Immunizations and vaccines;
- Well-baby care;
- Pap smears;
- Mammography;
- Screening tests, including colorectal cancer and prostate cancer screenings; and
- Bone density tests

Primary Care Provider

A Professional Provider as listed in the Personal Choice Network directory under "Primary Care Physicians" (General Practice, Family Practice or Internal Medicine), "Obstetricians/Gynecologists" or "Pediatricians".

Primary Care Services

Basic, routine Medical Care traditionally provided to individuals with:

- Common illnesses; and
- Common injuries; and
- Chronic illnesses.

Private Duty Nursing

Private Duty Nursing is Medically Necessary, complex skilled nursing care provided in the Member's private residence by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). It provides continuous monitoring and observation of a Member who requires frequent skilled nursing care on an hourly basis. Private Duty Nursing must be ordered by a Professional Provider who is involved in the oversight of the Member's care, in accordance with the Provider's scope of practice.

Professional Provider

A person or practitioner licensed, where required, and performing services within the scope of such licensure. The Professional Providers are:

- Audiologist;
- Autism Service Provider;
- Behavior Specialist;
- Certified Registered Nurse;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- Master's Prepared Therapist;
- Nurse Midwife;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Podiatrist;
- Psychologist;
- Registered Dietitian;
- Speech-Language Pathologist;
- Teacher of the hearing impaired.

Program

The benefit plan provided by the Group through an arrangement with the Health Benefit Plan.

Prosthetics (or Prosthetic Devices)

Devices (except dental Prosthetics), which replace all or part of:

- An absent body organ including contiguous tissue; or
- The function of a permanently inoperative or malfunctioning body organ.

Provider

A Facility Provider, PHO Facility Provider, Professional Provider, PHO Professional Provider, Ancillary Service Provider or PHO Ancillary Service Provider licensed where required.

Provider Incentive

An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group/population of Members.

Psychiatric Hospital

A Facility Provider, approved by the Health Benefit Plan, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness.

- Such services are provided by or under the supervision of an organized staff of Physicians.
- Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist

A Psychologist who is:

- Licensed in the state in which they practice; or
- Otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

Qualified Individual (for Clinical Trials)

A Member who meets the following conditions:

- The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and
- Either:
 - The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
 - The Member provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Member meeting the conditions described above.

Qualifying Clinical Trial

A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:

- Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH);
 - The Centers for Disease Control and Prevention (CDC);
 - The Agency for Healthcare Research and Quality (AHRQ);
 - The Centers for Medicare and Medicaid Services (CMS);
 - Cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - Any of the following, if the Conditions For Departments are met:
 - The Department of Veterans Affairs (VA);
 - The Department of Defense (DOD); or
 - The Department of Energy (DOE).
- The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Health Benefit Plan as a Qualifying Clinical Trial.

Registered Dietitian (RD)

A dietitian registered by a nationally recognized professional association of dietitians.

- A Registered Dietitian (RD) is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential "RD."

Registered Nurse (R.N.)

A nurse who:

- Has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program); and
- Is licensed by the appropriate state authority.

Rehabilitation Hospital

A Facility Provider, approved by the Health Benefit Plan, which is primarily engaged in providing rehabilitation care services on an Inpatient basis.

- Rehabilitation care services consist of:
 - The combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability.
- Services are provided by or under:
 - The supervision of an organized staff of Physicians.
- Continuous nursing services are provided:
 - Under the supervision of a Registered Nurse.

Reliable Evidence

Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

Residential Treatment Facility

A Facility Provider licensed and approved by the appropriate government agency and approved by the Health Benefit Plan, which provides treatment for:

- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency to partial, Outpatient or live-in patients who do not require acute Medical Care.

Retail Clinics

Retail Clinics are staffed by certified nurse practitioners trained to diagnose, treat and write prescriptions when clinically appropriate.

- Services are available to treat basic medical needs for: Urgent Care.
- Examples of needs are:
 - Sore throat;
 - Ear, eye or sinus infection;
 - Allergies;
 - Minor burns;
 - Skin infections or rashes; and
 - Pregnancy testing.

Routine Patient Costs Associated With Qualifying Clinical Trials

Routine patient costs include all items and services consistent with the coverage provided under this Program that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do NOT include:

- The investigational item, device, or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Self-Administered Prescription Drug

A Prescription Drug that can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:

- Oral drugs;
- Self-Injectable Drugs;
- Inhaled drugs; and
- Topical drugs.

Self-Injectable Prescription Drug (Self-Injectable Drug)

A Prescription Drug that:

- Is introduced into a muscle or under the skin with a syringe and needle; and
- Can be administered safely and effectively by either the Member or a caregiver without medical supervision, regardless of whether initial medical supervision and/or instruction is required.

Serious Mental Illness

Means any of the following biologically based Mental Illnesses: As defined by the American Psychiatric Association, in the most recent edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM):

- Schizophrenia;
- Bipolar disorder;
- Obsessive-compulsive disorder;
- Major depressive disorder;
- Panic disorder;
- Anorexia nervosa;
- Bulimia nervosa;
- Schizo-affective disorder;
- Delusional disorder; and
- Any other Mental Illness that is considered to be "Serious Mental Illness" by law.

Benefits are provided for diagnosis and treatment of these conditions when:

- Determined to be Medically Necessary; and
- Provided by a Provider.

Covered Services may be provided on an Outpatient or Inpatient basis.

Severe Systemic Protein Allergy

Means allergic symptoms to ingested proteins of sufficient magnitude to cause:

- Weight loss or failure to gain weight;
- Skin rash;
- Respiratory symptoms; and
- Gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

Short Procedure Unit

A unit which is approved by the Health Benefit Plan and which is designed to handle the following kinds of procedures on an Outpatient basis:

- Lengthy diagnostic procedures; or
- Minor surgical procedures.

In the absence of a Short Procedure Unit these are procedures which would otherwise have resulted in an Inpatient Admission.

Skilled Nursing Facility

An institution or a distinct part of an institution, other than one which:

- Is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency.

It is also an institution which:

- Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- Is otherwise acceptable to the Health Benefit Plan.

Sleep Studies

Refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to:

- Diagnose sleep disorders (For example, narcolepsy, sleep apnea, parasomnias);
- Initiate treatment for a sleep disorder; and/or
- Evaluate an individual's response to therapies such as continuous positive airway pressure (CPAP) or bi-level positive airway pressure device (BPAP).

Sound Natural Teeth

Teeth that are:

- Stable;
- Functional;
- Free from decay and advanced periodontal disease;
- In good repair at the time of the Accidental Injury/trauma; and
- Are not man-made.

Specialist Services

All Professional Provider services providing Medical Care or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Drug

A medication that meets certain criteria including, but not limited to:

- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a Professional Provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a Professional Provider regarding safety, side effects, and compliance.

- Access to the drug may be limited.

The Health Benefit Plan reserves the right to determine which Specialty Drug vendors and/or Professional Providers can dispense or administer certain Specialty Drugs.

Standard Injectable Drug

A medication that is either injectable or infusible:

- But is not defined by the Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug. Instead, these drugs need to be administered by a Professional Provider.

Standard Injectable Drugs include, but are not limited to:

- Allergy injections and extractions; and
- Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.

Surgery

The performance of generally accepted operative and cutting procedures including:

- Specialized instrumentations;
- Endoscopic examinations; and
- Other invasive procedures.

Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care.

Treatment of burns, fractures and dislocations are also considered Surgery.

Therapy Service

The following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Member:

- Cardiac Rehabilitation Therapy
Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells.
- Dialysis
The treatment that removes waste materials from the body for people with:
 - Acute renal failure; or
 - Chronic irreversible renal insufficiency.
- Infusion Therapy
The infusion of:
 - Drug;
 - Hydration; or
 - Nutrition (parenteral or enteral);
 - Into the body by a Professional Provider.

Infusion therapy includes: All professional services, supplies, and equipment that are required to safely and effectively administer the therapy.

Infusion may be provided in a variety of settings (For example, home, office, Outpatient) depending on the level of skill required to:

- Prepare the drug;
- Administer the infusion; and
- Monitor the Member.

The type of Professional Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Health Benefit Plan.

▪ Occupational Therapy

Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal (nerve, muscle and bone) functions which have been impaired by:

- Illness or injury;
- Congenital anomaly (a birth defect); or
- Prior therapeutic intervention.

Occupational Therapy also includes medically prescribed treatment concerned with improving the Member's ability to perform those tasks required for independent functioning, where such function has been permanently lost or reduced by:

- Illness or injury;
- Congenital anomaly (a birth defect); or
- Prior therapeutic intervention (Prior treatment).

This does NOT include services specifically directed towards the improvement of vocational skills and social functioning.

▪ Physical Therapy

Medically prescribed treatment of physical disabilities or impairments resulting from:

- Disease;
- Injury;
- Congenital anomaly; or
- Prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving:
 - Posture;
 - Mobility;
 - Strength;
 - Endurance;
 - Balance;
 - Coordination;
 - Joint Mobility;
 - Flexibility; and
 - The functional activities of daily living.

▪ Pulmonary Rehabilitation Therapy

A multidisciplinary, comprehensive program for Members who have a chronic lung disease.

Pulmonary rehabilitation is designed to:

- Reduce symptoms of disease;

- Improve functional status; and
 - Stabilize or reverse manifestations of the disease.
- **Radiation Therapy**
The treatment of disease by:
 - X-Ray;
 - Gamma ray;
 - Accelerated particles;
 - Mesons; or
 - Neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.
 - **Respiratory Therapy**
Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.
 - **Speech Therapy**
Medically prescribed services that are necessary for the diagnosis and/or treatment of speech and language disorders, due to conditions or events that result in communication disabilities and/or swallowing disorders:
 - Disease;
 - Surgery;
 - Injury;
 - Congenital and developmental anomalies (birth defects); or
 - Previous therapeutic processes.

Total Disability (or Totally Disabled)

Means that a Covered Employee who, due to illness or injury:

- Cannot perform any duty of their occupation or any occupation for which the Employee is, or may be, suited by education, training and experience; and
- Is not, in fact, engaged in any occupation for wage or profit.

A Dependent is totally disabled if: They cannot engage in the normal activities of a person in good health and of like age and sex.

The Totally Disabled person must be under the regular care of a Physician.

Urgent Care

Urgent Care needs are for sudden illness or Accidental Injury that require prompt medical attention but are not life-threatening and are not Emergency medical conditions when your Professional Provider is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care.

Urgent Care Centers

Facility Provider designed to offer immediate evaluation and treatment for sudden health conditions and accidental injuries that:

- Require medical attention in a non-Emergency situation; and
- When the Member's Professional Provider's office is unavailable.

Urgent Care is not the same as: Emergency Services (see definition of "Urgent Care" above).

Value-Based Program (VBP)

An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

IMPORTANT NOTICES

Regarding Experimental/Investigative Treatment:

The Health Benefit Plan does not cover treatment it determines to be Experimental/Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Health Benefit Plan acknowledges that situations exist when a Member and their Physician agree to utilize Experimental/Investigative treatment. If a Member receives Experimental/Investigative treatment, the Member shall be responsible for the cost of the treatment. A Member or their Physician should contact the Health Benefit Plan to determine whether a treatment is considered Experimental/Investigative. The term "Experimental/Investigative" is defined in the **Important Definitions** section.

Regarding Treatment Which Is Not Medically Necessary:

The Health Benefit Plan only covers treatment which it determines Medically Necessary. An In-Network Provider accepts the Health Benefit Plan's decision and contractually is not permitted to bill the Member for treatment which the Health Benefit Plan determines is not Medically Necessary unless the In-Network Provider specifically advises the Member in writing, and the Member agrees in writing that such services are not covered by the Health Benefit Plan, and that the Member will be financially responsible for such services. An Out-of-Network Provider, however, is not obligated to accept the Health Benefit Plan's determination and the Member may not be reimbursed for treatment which the Health Benefit Plan determines is not Medically Necessary. The Member is responsible for these charges when treatment is received by an Out-of-Network Provider. The Member can avoid these charges simply by choosing an In-Network Provider for the Member's care. The term "Medically Necessary" is defined in the **Important Definitions** section.

Regarding Treatment for Cosmetic Purposes:

The Health Benefit Plan does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Health Benefit Plan acknowledges that situations exist when a Member and their Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Member is responsible for the cost of the treatment. A Member or their Physician should contact the Health Benefit Plan to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the **Exclusions - What Is Not Covered** section.

Regarding Coverage for Emerging Technology:

While the Health Benefit Plan does not cover treatment it determines to be Experimental/Investigative, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Health Benefit Plan uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Member, the Health Benefit Plan researches all scientific information available from these expert sources. Following this analysis, the Health Benefit Plan makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Member or their Provider should contact the Health Benefit Plan to determine whether a proposed treatment is considered "emerging technology" and whether the Provider is considered an eligible Provider to perform the "emerging technology" Covered Service. The Health Benefit Plan maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

Regarding Use of Out-of-Network Providers

While Personal Choice has an extensive network, it may not contain every provider that the Member elects to see. To receive the Maximum benefits available under this Program, the Member must obtain Covered Services from In-Network Providers that participate in the Personal Choice Network or is a BlueCard Provider.

In addition, the Members Personal Choice program allows the Member to obtain Covered Services from Out-of-Network Providers. If the Member uses an Out-of-Network Provider the Member will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance. In certain instances, the Out-of-Network Provider also may charge the Member for the balance of the Provider's bill. This is true regardless of the reason the Member uses an Out-of-Network Provider including, but not limited to, by choice, for level of expertise, for convenience, for location, because of the nature of the services, based on the recommendation of a Provider or network sufficiency. However, if Emergency Care is provided by certain Out-of-Network Providers (For example, ambulance services), in accordance with applicable law, the Health Benefit Plan will reimburse the Out-of-Network Provider at an In-Network rate directly. In this instance the specified Out-of-Network Provider will not bill the Member for amounts in excess of the Health Benefit Plan's payment for the Emergency Care. For payment of Covered Services provided by an Out-of-Network Provider, please refer to the definition of "Covered Expense".

For Covered Services received from an Out-of-Network Provider, payment will be made directly to the Member and the Member will be responsible for reimbursing the Out-of-Network Provider. However, the Health Benefit Plan reserves the right, in its sole discretion, to make payments directly to the Out-of-Network Provider

For specific terms regarding Out-of-Network Providers, please refer to the following sections: **Important Definitions**; including but not limited to the definition of "Covered Expense" and "Out-of-Network Provider", Payment of Providers and Payment Methods.

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Discretionary Authority

The Health Benefit Plan or Plan Administrator, as applicable, retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Health Benefit Plan or Plan Administrator, as applicable, determines in its discretion that the Member is entitled to them.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigative", "cosmetic", or "emerging technology", the Member, or their Provider, should contact the Health Benefit Plan for a coverage determination. That way the Member and the Provider will know in advance if the treatment will be covered by the Health Benefit Plan.

In the event the treatment is not covered by the Health Benefit Plan, the Member can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Health Benefit Plan for coverage determinations, please see the Precertification and Prenotification requirements in the *General Information* section.

RIGHTS AND RESPONSIBILITIES

To obtain a list of "Rights and Responsibilities", please log on to http://www.ibx.com/members/quality_management/member_rights.html or the Member should call the Customer Service telephone number that is listed on their Identification Card to receive a printed copy.

LANGUAGE AND COVERAGE CHANGES

2019 PREVENTIVE SCHEDULE

This schedule is a reference tool for planning your preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your health care provider is always your best resource for determining if you're at increased risk for a condition. Some services may require precertification/preapproval. If you have questions about this schedule, precertification/preapproval, or your benefit coverage, please call the Customer Service number on the back of your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: <ul style="list-style-type: none"> • High blood pressure screening • Behavioral counseling for skin cancer 	One exam annually for all adults
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males age 65 to 75 years with a history of smoking
Abnormal blood glucose and Type 2 diabetes mellitus screening and intensive counseling interventions	Abnormal blood glucose and type 2 diabetes screening for adults 40 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals 40 to 70 years who are overweight or obese with abnormal blood glucose up to 24 sessions per year
Alcohol and drug use/misuse screening and behavioral counseling intervention	Screening for all adults Behavioral counseling in a primary care setting for adults with a positive screening result for drug or alcohol use/misuse
Colorectal cancer screening	Adults age 50 to 75 years using any of the following tests: <ul style="list-style-type: none"> • Fecal occult blood testing: once a year • Highly sensitive fecal immunochemical testing: once a year • Flexible sigmoidoscopy: once every five years • CT colonography: once every five years • Stool DNA testing: once every three years • Colonoscopy: once every 10 years

Depression screening	Annually for all adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection
Hepatitis C virus (HCV) screening	All asymptomatic adults age 18 years and older or as a one-time screening for adults born between 1945 and 1965
High Blood Pressure Screening	Adults age 18 years or older with increased risk once a year Adults age 18 to 39 years with no other risk factors once every 3 to 5 years Adults age 40 years once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults age 18 years or older at increased risk for tuberculosis
Lipid disorder screening	Adults 40-75 years once every 5 years
Lung cancer screening	Adults age 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years
Obesity screening and behavioral intervention	Obesity screening for all adults Behavioral intervention for adults with a body mass index (BMI) of 30 kg/m ² or higher
Syphilis infection screening	All adults at increased risk for syphilis infection
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults age 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year
Counseling for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Tobacco use counseling	All adults who use tobacco products
MEDICATIONS	
Low Dose Aspirin	Adults 50-59 years for the primary prevention of cardiovascular disease and colorectal cancer
Prescription bowel preparation	When used in conjunction with a preventive colorectal cancer screening procedure (That is, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)
Statin	Adults 40-75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10 year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS

Vaccine ↓ → Age Group	19–21 years	22–26 years	27–49 years	50–64 years	≥65 years
Influenza	1 dose annually				
Tetanus, diphtheria, pertussis (Td/Tdap)	1 dose Tdap, then Td booster every 10 yrs				
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)				
Varicella	2 doses				
Recombinant zoster vaccine (RZV) (preferred)	2 doses RZV (preferred)				
or Zoster Vaccine Live (ZVL)	1 dose ZVL				
Human papillomavirus (HPV)–Female	2 or 3 doses depending on age at series initiation				
Human papillomavirus (HPV)–Male	2 or 3 doses depending on age at series initiation				
Pneumococcal 13-valent conjugate (PCV13)	1 dose				
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication				
Hepatitis A	2 or 3 doses depending on vaccine				
Hepatitis B	3 doses				
Meningococcal 4-valent conjugate (MenACWY)	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains				
Meningococcal B (MenB)	2 or 3 doses depending on vaccine				
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication				



Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection



Recommended for adults with other indications

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
Prenatal Care Visits Services that may be provided during the prenatal care visits include, but are not limited to the following: <ul style="list-style-type: none"> • Preeclampsia Screening 	For all pregnant females
Well-woman visits Services that may be provided during the well-woman visit include but are not limited to the following: <ul style="list-style-type: none"> • BRCA-related cancer risk assessment • Discussion of chemoprevention for breast cancer • Intimate partner violence screening • Primary care interventions to promote and support breastfeeding • Recommended preventive preconception and prenatal care services • Tobacco use counseling • Urinary Incontinence Screening 	At least annually
SCREENINGS	
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with either personal history or family history of a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling
Breast cancer screening (2D or 3D mammography)	All females age 40 years and older
Cervical cancer screening (Pap test)	Ages 21 to 65: Every three years Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval
Chlamydia screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
Diabetes Mellitus Screening After Pregnancy	Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus

Depression Screening	All pregnant and post-partum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Gonorrhea screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
Hepatitis B virus (HBV) screening	All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant females
Human papillomavirus (HPV) screening	Age 30 and older: Every three years Ages 30 to 65: Every five years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval
Iron-deficiency anemia screening	All asymptomatic pregnant females
Osteoporosis (bone mineral density) screening	Every two years for females younger than 65 years who are at high risk for osteoporosis Every two years for females 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
Preeclampsia Screening	All pregnant females without a known diagnosis of preeclampsia or hypertension
RhD incompatibility screening	All pregnant females and follow-up testing for females at higher risk
Syphilis screening	All pregnant females at first prenatal visit For high-risk pregnant females, repeat testing in the third trimester and at delivery Females at increased risk for syphilis infection
Tobacco Use Counseling	All pregnant females who smoke tobacco products
MEDICATIONS	
Breast cancer chemoprevention	Asymptomatic females age 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic Acid	Daily folic acid supplements for all females planning for or capable of pregnancy
Low Dose Aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation
MISCELLANEOUS	
Breastfeeding supplies/support/counseling	Comprehensive lactation support/counseling for all pregnant women and during the postpartum period Breastfeeding supplies
Reproductive education and counseling, contraception, and sterilization	All females with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pre-birth exams	All expectant parents for the purpose of establishing a pediatric medical home
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following:	All children up to 21 years of age, with preventive exams provided at:
<ul style="list-style-type: none"> • Behavioral counseling for skin cancer prevention • Blood pressure screening • Congenital heart defect screening • Counseling and education provided by healthcare providers to prevent initiation of tobacco use • Developmental surveillance • Dyslipidemia risk assessment • Hearing risk assessment for children 29 days or older • Height, weight, and body mass index measurements • Hemoglobin/hematocrit risk assessment • Obesity screening • Oral health risk assessment • Psychosocial/behavioral assessment 	<ul style="list-style-type: none"> • 3-5 days after birth • By 1 month • 2 months • 4 months • 6 months • 9 months • 12 months • 15 months • 18 months • 24 months • 30 months • 3 years-21 years: annual exams
SCREENINGS	
Alcohol, tobacco, and drug use/misuse screening and behavioral counseling intervention	Annually for all children 11 years of age and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Autism and developmental screening	All children during the 18 month and 24 month preventive exams
Bilirubin Screening	All newborns
Chlamydia screening	All sexually active children up to age 21 years
Depression screening	Annually for all children age 12 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
Gonorrhea screening	All sexually active children up to age 21 years
Hearing screening for newborns	All newborns
Hearing screening for children 29 days or older	Following a positive risk assessment or in children where hearing screening is indicated

Hepatitis B virus (HBV) screening	All asymptomatic adolescents at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn Bilirubin Screening	All newborns
Newborn metabolic screening panel (For example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns
Syphilis screening	All sexually active children up to age 21 years
Visual impairment screening	All children up to age 21 years
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	Semiannually for all sexually active adolescents at increased risk for sexually transmitted infections
Obesity Screening and Behavioral Counseling	Screening is part of the preventive exam for children ages 6 years and older. Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater
MEDICATIONS	
Fluoride	Oral fluoride for children age 6 months to 5 years whose water supply is deficient in fluoride
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth
MISCELLANEOUS	
Fluoride varnish application	Twice a year for all infants and children starting at age of primary tooth eruption to 5 years of age
Hemoglobin/hematocrit testing	Following a positive risk assessment or in children where laboratory testing is indicated for children up to age 21 years
Tuberculosis testing	All children up to age 21 years

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16-18 yrs
Hepatitis B (HepB)	1 st dose	← 2 nd dose →			← 3 rd dose →					← Catch-up →						
Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)			1 st dose	2 nd dose												
Diphtheria, tetanus, & acellular pertussis (DTaP; <7 yrs)			1 st dose	2 nd dose	3 rd dose				← 4 th dose →			5 th dose				
<i>Haemophilus influenzae</i> type b (Hib)			1 st dose	2 nd dose				← 3 rd or 4 th dose →		← Catch-up →						
Pneumococcal conjugate (PCV13)			1 st dose	2 nd dose	3 rd dose			← 4 th dose →		← Catch-up →						
Inactivated poliovirus (IPV; <18 yrs)			1 st dose	2 nd dose	← 3 rd dose →							4 th dose	← Catch-up →			
Influenza (IM)					Annual vaccination (IV) 1 or 2 doses										Annual vaccination (IV) 1 dose only	
Measles, mumps, rubella (MMR)							← 1 st dose →					2 nd dose	← Catch-up →			
Varicella (VAR)							← 1 st dose →					2 nd dose	← Catch-up →			
Hepatitis A (HepA)							← 2-dose series →					← Catch-up →				
Meningococcal (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)			← Catch-up →											1 st dose		2 nd dose
Tetanus, diphtheria, & acellular pertussis (Tdap; >7 yrs)															(Tdap)	
Human papillomavirus (HPV)															(2-dose series)	
Meningococcal B														← Catch-up →		
Pneumococcal polysaccharide (PPSV23)												← Catch-up →				

Range of recommended ages for all children
 Range of recommended ages for catch-up immunization
 Range of recommended ages for certain high-risk groups
 Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
 No recommendation

BASIC PRESCRIPTION DRUG PLAN

A Group Contract

By and Between

QCC Insurance Company
(Called "the Carrier")
A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

And

Group Name: INSIGHT PA CYBER CHARTER SCHOOL

Group Contract Number(s): 10449420

In consideration of the Group's application for coverage and the payment of premiums when due and subject to all terms of this Prescription Drug Group Contract (the Contract), the Carrier hereby agrees to provide each eligible Covered Person of the Group and each eligible Covered Person of the Group's subsidiary or affiliated units, if any, under the above Group Number(s), the benefits as described in the Basic Prescription Drug Plan Booklet/Certificate for eligible persons who enroll hereunder, in accordance with the terms, conditions, limitations, and exclusions of this Contract.

All of the provisions of the booklet/certificate(s) and all modifications made to such booklet/certificate(s), attached to and made a part of the Contract, apply to the Contract as if fully set forth in the Contract.

The Group may accept this Contract by making required payments to the Health Benefit Plan. Such acceptance renders all terms and provisions hereof binding on the Health Benefit Plan and the Group.



Paula Sunshine
SVP and Chief Marketing Executive

CONTRACT TABLE OF CONTENTS

CONTRACT DEFINITIONS3
CONTRACT PROVISIONS.....3
SCHEDULE OF BENEFIT BOOKLET(S)3
CONTRACT RATES3
GROUP APPLICATION3
BENEFIT BOOKLET(S).....Attached

CONTRACT DEFINITIONS

AMENDMENT – A modification to this Contract or Benefit Booklet(s), which changes the original terms of this Contract or the Benefit Booklet(s). The changes contained in the Amendment can take the form of one of the following:

- A. A statutory Amendment, which reflects a change that has been automatically made to satisfy a requirement(s) of any state law, federal law or regulation that would apply to this Contract, as provided in the "Compliance With Law" subsection of the **Contract Provisions** section;
- B. A health care Amendment, which reflects a change in the Group's benefits where:
 - 1. The benefits are for services and supplies provided through the Health Benefit Plan's Providers; and
 - 2. The change applies to all group contracts which include these benefits.

When this Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the health care Amendment;

- C. A universal Amendment, which reflects a change in the Health Benefit Plan's administration of its group benefits and is intended to apply to all group contracts which are affected by the change.

When the Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the universal Amendment, unless the Group has rejected the Amendment, in writing, prior to its effective date; or

- D. Any combination of the Amendments shown above.

APPLICANT: An employee who applies for coverage under this Contract which the Health Benefit Plan has entered into with the Group.

APPLICATION AND APPLICATION CARD: The request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Health Benefit Plan, whether such request was made under a prior carrier's contract which is superseded by this Contract, or under this Contract.

EFFECTIVE DATE: 12:01 A.M. on the date, specified in the Group Application of this Contract, on which coverage under this Contract commences for the Group.

GROUP (CONTRACTHOLDER): Any entity which employs or represents enrolled employees and, as agent for such enrolled employees, is acceptable to the Health Benefit Plan and has agreed to remit premium to the Health Benefit Plan on behalf of enrolled employees and to receive any information from the Health Benefit Plan on behalf of enrolled employees.

CONTRACT PROVISIONS

A. ENTIRE CONTRACT; CHANGES

1. The entire Contract consists of:
 - a. The booklet/certificate(s) attached to this Contract;
 - b. Any Amendment made to this Contract or Benefit Booklet(s);
 - c. Individual applications, if any, of the persons covered; and
 - d. The forms shown in **Contract Table of Contents**, as of the Effective Date of the Contract between the Group and the Health Benefit Plan.

No change in this Contract will be effective until approved by an authorized officer of the Health Benefit Plan. This approval must be noted on or attached to this Contract via an Amendment, signed by an officer of the Health Benefit Plan. No agent or representative of the Health Benefit Plan, other than an officer of the Health Benefit Plan may otherwise change this Contract or waive any of its provisions.

Fraudulent Statements

All statements made by the Group or by any individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to claim under this Contract, unless it is contained in a written instrument furnished to the Group or a Member.

2. The Group may not transfer enrollment to another type of Contract issued by the Health Benefit Plan until the expiration of a period of one (1) year from the Effective Date of this Contract and thereafter from year to year except as otherwise approved by the Health Benefit Plan.

B. TERMINATION OF THE GROUP CONTRACT

1. The Group may terminate this Contract on any Anniversary Date by giving written notice to the Health Benefit Plan at least thirty (30) days in advance.
2. This Contract will be terminated for the Group's nonpayment of premium, subject to the "Grace Period" subsection of this **Contract Provisions** section.
3. The Health Benefit Plan reserves the right to terminate this Contract by giving thirty (30) days notice to the Group, in writing, if the Group fails to meet the Health Benefit Plan's Underwriting Guidelines including, but not limited to, the Group's minimum participation requirements.
4. This Contract will be terminated, at the Health Benefit Plan's option, for fraud or intentional misrepresentation of a material fact by the Group.

5. The Health Benefit Plan may, at its option, amend this Contract at least annually. If the Group does not agree to such change(s), the Group must notify the Health Benefit Plan and the Group may terminate this Contract at the end of the then current contract term.
6. Either the Group or the Health Benefit Plan may at any time cancel this Contract or the Health Benefit Plan may at any time migrate your group coverage under this Contract to another benefit program by giving written notice to the other party at least ninety (90) days in advance.

C. **GRACE PERIOD**

This Contract has a grace period of thirty (30) days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period the Contract will stay in force unless prior to the date payment was due the Group gave timely written notice to the Health Benefit Plan that the Contract is to be cancelled. If the Group does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period. The Group will be required to reimburse the Health Benefit Plan for all outstanding premiums including the premium for the grace period.

D. **APPLICABLE LAW**

This Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

E. **COMPLIANCE WITH LAW**

If the provisions of the Contract do not conform to the requirements of any state law, federal law or regulation that would be applicable to the Contract, the Contract is automatically changed to comply with the Health Benefit Plan's interpretation of the requirements of that law or regulation.

F. **NOTICE**

Any notice required under this Contract must be in writing. Notice given to the Group will be sent to the Group's address stated in the **Group Application**. Notice given to the Health Benefit Plan will be sent to the Health Benefit Plan's address stated in the **Group Application**. Notice given to a Member will be given to the Member in care of the Group or sent to the Member's last address furnished to the Health Benefit Plan by the Group. The Group, the Health Benefit Plan, or a Member may, by written notice, indicate a new address for giving notice.

G. **IDENTIFICATION CARDS**

The Health Benefit Plan will provide Identification Cards to Members or to the Group, depending on the direction of the Group. Any Identification Card issued by the Health Benefit Plan in connection with the coverage's provided by this Contract, are for identification only. Possession of the Identification Card does not convey any rights to benefits under this Contract. If any Member permits another person to use the Member's Identification Card, the Health Benefit Plan may revoke that Member's Identification Card.

H. **BENEFIT BOOKLETS**

The Health Benefit Plan will also provide to each Member of an enrolled Group a Benefit Booklet entitled "Basic Prescription Drug Program". It will describe the Member's coverage under the Contract. It will include:

1. To whom the Health Benefit Plan pays benefits;
2. Any protection or rights when the coverage ends; and
3. Claim rights and requirements.

I. **TIMELY FILING**

1. The Health Benefit Plan will not be liable under this Contract unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within twenty (20) days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.
2. Failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.

J. **RECORDS OF EMPLOYEE ELIGIBILITY AND CHANGES IN EMPLOYEE ELIGIBILITY**

1. The Group must furnish the Health Benefit Plan with any data required by the Health Benefit Plan for coverage of Members under this Contract. In addition, the Group must provide written notification to the Health Benefit Plan within thirty-one (31) days of the effective date of any changes in a Member's coverage status under this Contract.
2. All notification by the Group to the Health Benefit Plan must be furnished on forms approved by the Health Benefit Plan. The notification must include all information required by the Health Benefit Plan to effect changes.
3. Clerical errors or delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate.
4. If Contract benefits are provided by and/or approved by the Health Benefit Plan for Covered Services rendered to a Member before the Health Benefit Plan receives notice of the Member's termination under the Contract, the cost of such benefits will be the sole responsibility of the Member. The effective date of termination of a Member under the Contract shall not be more than thirty (30) days before the first day of the month in which the Group notified the Health Benefit Plan of such termination.

K. **RELEASE OF INFORMATION**

The Health Benefit Plan may furnish membership and/or coverage information to affiliated plans or other entities for the purpose of claims processing or facilitating patient care.

The Health Benefit Plan reserves the right to obtain personal health information, medical records, and/or authorizations for care and treatment, in order to establish the Medical Necessity of a treatment, procedure, drug or device for purposes of paying benefits under this Contract.

When the Health Benefit Plan needs to obtain consent for the release of personal health information, medical records, and/or authorization of care and treatment, or to have access to information from a Member who is unable to provide it, the Health Benefit Plan will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Member.

L. TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim Incurred commencing after the expiration of such three (3) year period.

M. LIMITATIONS OF THE CARRIER'S LIABILITY

The Health Benefit Plan shall not be liable for injuries or damage resulting from acts or omissions of any officer or employee of the Health Benefit Plan or of any Provider or other person furnishing services or supplies to the Member; nor shall the Health Benefit Plan be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

N. RIGHT TO RECOVER PAYMENTS IN ERROR

If the Health Benefit Plan should pay for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.

O. RIGHT TO ENFORCE CONTRACT PROVISIONS

If the Health Benefit Plan shall choose to waive their rights under this Contract regarding a specific term or provision, it shall not be interpreted as a waiver of their right to otherwise administer or enforce this Contract in strict accordance with the terms and provisions of this Contract.

P. RELATIONSHIPS AMONG PARTIES AFFECTED BY THE CONTRACT

1. The relationship that exists between the Health Benefit Plan and any Provider who is a Member or Member Mail Order Pharmacy is that of an independent contractor. No Provider, who is a Member Pharmacy, is an agent or employee of the Health Benefit Plan. The Health Benefit Plan or any employee of the Health Benefit Plan is not an employee or agent of a Provider who is a Member or Member Mail Order Pharmacy. Each Member or Member Mail Order Pharmacy will maintain the provider-patient relationship with the Members under the Contract and is solely responsible to Members for services and supplies furnished to Members.

2. Neither the Group nor any Member under the Contract is the agent or representative of the Health Benefit Plan. Neither the Group nor any Member under the Contract will be liable for any acts or omissions:
 - a. Of the Health Benefit Plan, its agents or employees; or
 - b. Of any Provider with which the Health Benefit Plan, its agents or employees make arrangements for furnishing services and supplies to Members.
3. The choice of a Provider is solely the Member's choice.

Q. PHARMACY PROVIDERS

The Health Benefit Plan anticipates that it will pass on a high percentage of the average expected Prescription Drug rebates it receives from its pharmacy benefits manager (PBM), which is an affiliate of Independence Blue Cross, through reductions in future premium costs to the Group. Expected Prescription Drug rebates are based on historical drug rebates received by the Health Benefit Plan from its PBM, adjusted for known and anticipated changes in future rebate amounts. This includes, without limitation, adjustments for drugs for which the patent is expiring or changes in the Health Benefit Plan's PBM. While the Health Benefit Plan anticipates that it will be able to pass on a high percentage of the average expected Prescription Drug rebates, there may be instances when this amount could vary based on actual rebates that are either higher or lower than expected (e.g., the introduction of new drugs may result in a higher rebate) or other market conditions that are beyond the Health Benefit Plan's control. The Group acknowledges that any rebate amounts beyond amounts that are passed on to the Group are for the sole benefit of the Health Benefit Plan and that neither the Group nor persons covered under the benefit program, nor anyone else is entitled to receive any portion of such savings whether as part of any claims settlement or otherwise.

R. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Group is hereby notified:

This Contract is between the Member or Group, on behalf of itself and Members, and the Health Benefit Plan. The Health Benefit Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows the Health Benefit Plan to use the familiar Blue Cross words and symbols. The Health Benefit Plan, which is entering into this Contract, is not contracting as an agent of the national Association. Only the Health Benefit Plan shall be liable to the Member or Group, on behalf of itself and the Members for any of the Health Benefit Plan's obligations under this Contract. This paragraph does not add any obligations to this Contract.

S. **PREMIUM RATES**

Premium rates may be changed on the Anniversary Date of the Contract during any year in which this Contract remains in effect, provided written notice of such proposed change shall be given to the Group by the Health Benefit Plan on its own behalf not later than thirty (30) days prior to the Anniversary Date of the Contract. Provided, however, that if less than thirty (30) days notice is given by the Health Benefit Plan, the new premium rate will be effective on the first day of the month following the Anniversary Date. It is also agreed that notice of such change to the Group is notice to those Members enrolled hereunder, and that payment of the new charges shall constitute acceptance of the change in premium rates. In addition, the premium rates may be changed at any time upon mutual consent of the parties.

If the Health Benefit Plan determines that a change in the Contract is required by statute or regulation which increases the Health Benefit Plan's risk under this Contract, the Health Benefit Plan may change the premium upon thirty (30) days written notice.

The Health Benefit Plan may from time to time determine to abate (all or some of) the premium due under this Contract for particular period(s).

Any abatement of premium by the Health Benefit Plan represents a determination by the Health Benefit Plan not to collect the premium for the applicable period(s) and does not effect a reduction in the rates under this Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

The Health Benefit Plan may from time to time offer programs such as wellness programs and other incentive or reward programs to the Group and Members enrolled hereunder.

T. **NON-DISCRIMINATION RIGHTS**

The Member has the right to receive health care services without discrimination:

1. Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
2. For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
3. Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
4. Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

SCHEDULE OF BENEFIT BOOKLET(S)

Subject to the exclusions, conditions and limitations set forth in the attached Benefit Booklet(s), a Member is entitled to benefits for Prescription Drugs as described in the Benefit Booklet's ***Your Prescription Drugs Benefits*** section. Payment allowances for Prescription Drugs are described in the ***Your Prescription Drugs Benefits*** section of the Benefit Booklet(s).

CONTRACT RATES

<u>Rating</u>	<u>Total</u>
Single	\$172.10
Parent & Child	\$306.86
Parent & Children	\$306.86
Husband & Wife	\$396.01
Family	\$504.95

GROUP APPLICATION

Application to:

QCC Insurance Company

whose main office address is
1901 Market Street
Philadelphia, PA 19103

By: **INSIGHT PA CYBER CHARTER SCHOOL**

whose main office address is:

350 Eagleview Blvd
suite 350
Exton, PA 19341

For Group Contract Number(s): 10449420; with an

Effective Date of: January 1, 2019; and an Anniversary Date of: December 31, 2019; and will renew for a further period of twelve (12) consecutive months and thereafter, from year to year, unless terminated as provided by this Contract; and for the coverage afforded by this Contract, and the terms of which are hereby approved and accepted by the Group to be executed on the Effective Date shown above.

The Application is made to the Contract and it is agreed that this Application supersedes any previous Application for this Contract. The signature below is evidence of QCC Insurance Company's acceptance of the Group Contractholder's Application on the terms hereof, and constitutes execution of this Group Contract attached hereto on behalf of QCC Insurance Company.

QCC INSURANCE COMPANY



Brian Loble
President and SVP, Commercial and Consumer markets

Attest:



Paula Sunshine
SVP and Chief Marketing Executive

Date: March 26, 2019

SELECT DRUG PROGRAM[®]



Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

QCC Insurance Company
(Hereafter called "The Health Benefit Plan")

Group (Contractholder)
(Hereafter called "The Contractholder")

BASIC PRESCRIPTION DRUG PROGRAM

This Booklet is subject to the laws of the Commonwealth of Pennsylvania

QCC Insurance Company
(Hereafter called "the Health Benefit Plan")

**GROUP HEALTH BENEFITS
BENEFIT BOOKLET**

The Health Benefit Plan certifies that Employees/Members in an eligible class of the Contractholder are entitled to the benefits described in this Benefit Booklet, subject to the eligibility and effective date requirements of the Group Contract.

This Benefit Booklet replaces any and all Benefit Booklets previously issued under any group contracts issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contractholder. This Benefit Booklet is a summary of the Contract provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

QCC INSURANCE COMPANY



Brian Loble
President and SVP, Commercial and
Consumer markets

ATTEST:



Paula Sunshine
SVP and Chief Marketing Executive

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deutsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Dii baa akó ninizin: Dii saad bee yánilti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jüik'eh. Hódiilnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Program provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800- 368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

BASIC PRESCRIPTION DRUG PROGRAM

TABLE OF CONTENTS

SECTION 1. INTRODUCTION.....	1
SECTION 2. PRESCRIPTION DRUG BENEFITS.....	3
SECTION 3. PRESCRIPTION DRUG EXCLUSIONS.....	6
SECTION 4. ELIGIBILITY UNDER THE PROGRAM.....	8
SECTION 5. GENERAL INFORMATION.....	10
SECTION 6. RESOLVING PROBLEMS (COMPLAINTS/APPEALS).....	17
SECTION 7. IMPORTANT DEFINITIONS.....	22

SECTION 1.

INTRODUCTION

This Benefit Booklet has been prepared so that the Member may become acquainted with the Prescription Drug program available to employees who are eligible and enrolled in it. The benefits described are subject to the terms of the Group Contract issued by QCC Insurance Company (referred to as the Health Benefit Plan). Changes impacting this Benefit Booklet will be evidenced by a Notice of Change to the Benefit Booklet and/or a revised edition of the Benefit Booklet.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Necessary, as determined by the Health Benefit Plan. The amount of benefits for Prescription Drugs will not be more than the amount charged by the Pharmacy and will not be greater than any maximum amount or limit described or referred to in this Benefit Booklet.

See "Important Notice" below:

Important Notice: Regarding Experimental Drugs Or Investigative Drugs

The Health Benefit Plan does not cover Drugs it determines to be experimental or investigative in nature because those Drugs are not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Health Benefit Plan acknowledges that situations exist when a Member and the Member's Physician agree to utilize Experimental Drugs or Investigative Drugs. If a Member is prescribed and dispensed Experimental Drugs or Investigative Drugs, the Member shall be responsible for the cost of the Drugs. A Member or the Member's Physician may contact the Health Benefit Plan to determine whether a Drug is considered an Experimental Drug or Investigative Drug. The term "Experimental Drug or Investigative Drug" is defined in the ***Important Definitions*** section of this Benefit Booklet.

Important Notice: Regarding Treatment Which Is Not Medically Necessary

The Health Benefit Plan only covers Drugs which it determines Medically Necessary. A Member Pharmacy accepts our decision and will not bill the Member for Drugs which the Health Benefit Plan determines are not Medically Necessary without the Member's consent. A Non-Member Pharmacy, however, is not obligated to accept the Health Benefit Plan's determination and the Member may not be reimbursed for Drugs which the Health Benefit Plan determines are not Medically Necessary. The Member is responsible for these charges when Drugs are dispensed by a Non-Member Pharmacy. The Member can avoid these charges simply by choosing a Member Pharmacy for their care.

The terms "Medically Necessary", "Member Pharmacy", and "Non-Member Pharmacy" are defined in the ***Important Definitions*** section of this Benefit Booklet.

Important Notice: Regarding Drugs Used For Cosmetic Purposes

The Health Benefit Plan does not cover Drugs which it determines are prescribed for cosmetic

purposes because they are not necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Health Benefit Plan acknowledges that situations exist when a Member and the Member's Physician decide to pursue a course utilizing Drugs used for Cosmetic Purposes. In such cases, the Member is responsible for the cost of the Drugs. A Member or the Member's Physician may contact the Health Benefit Plan to determine whether a Drug is considered prescribed for cosmetic purposes.

The term "Drugs used for Cosmetic Purposes" is defined in the ***Important Definitions*** section of this Benefit Booklet.

Regarding Non-Discrimination Rights:

The Member has the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Discretionary Authority

The Health Benefit Plan or Plan Administrator, as applicable, retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Health Benefit Plan or Plan Administrator, as applicable, determines in its discretion that the Member is entitled to them.

SECTION 2.

PRESCRIPTION DRUG BENEFITS

Subject to the Exclusions, conditions and limitations of the Program, a Member is entitled to benefits for Prescription Drugs as described in this Benefit Booklets **Prescription Drug Benefits** section subject to any Copayment, Coinsurance or Deductible, and in the amounts as specified below. For services which are not provided by a Member Pharmacy, the Member may pay a higher Copayment, Coinsurance level and/or Deductible as described below.

Prescription Drugs Ordered From A Member Pharmacy

Benefits will be provided for covered Prescription Drugs appearing on the Drug Formulary and that are prescribed by a Physician and dispensed by a Member Pharmacy in accordance with the Prescription Drug Order presented by the Member or the Member's Health Care Practitioner. Benefits are available for up to a 30 day supply, or the appropriate therapeutic limit, whichever is less.

Benefits are also available for diabetic supplies such as blood testing strips, insulin syringes and lancets. A Member Pharmacy will furnish requested Prescription Drugs in accordance with the terms and conditions of the Group Contract and will not collect from or charge a Member any amount in excess of the applicable Copayment and Coinsurance, and/or Deductible.

The Health Benefit Plan will only provide benefits for covered specialty Drugs through the Pharmacy Benefits Manager's (PBM's) Specialty Pharmacy Program for the appropriate cost sharing indicated in the "Copayments And Coinsurance" subsection of the **Prescription Drug Benefits** section for Member Pharmacies. Benefits are available for up to a 30 day supply*. No benefits shall be provided for Prescription Drugs obtained from a Specialty Pharmacy Program other than the PBM's Specialty Pharmacy Program. The responsibility to initiate the Specialty Pharmacy process is the Members'.

- * Select specialty Drugs will be subject to 'split fill' whereby the initial prescription will be dispensed in two separate amounts. The first amount is dispensed without delay. The second amount may be dispensed subsequently, allowing time for any necessary clinical intervention due to medication side effects that may require dose modification or therapy discontinuation. The Member's cost share is prorated for each amount of the split fill.

Prescription Drugs Ordered From A Non-Member Pharmacy

Benefits will be provided for covered Prescription Drugs appearing on the Drug Formulary and that are prescribed by a Physician and dispensed to a Member for Prescription Drugs purchased by a Member from a Non-Member Pharmacy if:

- Prescription Drugs were dispensed subject to a Prescription Drug Order;
- The Member submits to the Health Benefit Plan a completed claim form and proper proof of payment; and
- The Prescription Drug is not excluded under the Group Contract.

The Health Benefit Plan shall reimburse the Member's Allowable Charges less any applicable Deductible, Copayment and Coinsurance for up to a 30 day supply of the purchased Prescription Drug, or the appropriate therapeutic limit, whichever is less.

Prescription Drugs Ordered From A Member Mail Order Pharmacy

Benefits shall be provided for covered Prescription Drugs , appearing on the Drug Formulary, for chronic conditions ordered by mail by a Member or the Member's prescribing Health Care Practitioner and submits to a Member Mail Order Pharmacy a written Prescription Drug Order specifying the amount of the Prescription Drug to be supplied. Benefits shall be available for up to a 90 day supply of a Covered Drug, or the appropriate therapeutic limit, whichever is less, subject to the amount specified in the Prescription Drug Order and applicable law. In addition, benefits shall also be provided for covered Prescription Drugs prescribed by a Physician for a chronic condition and dispensed by a participating Act 207 retail Pharmacy. The cost sharing indicated in the "Copayments and Coinsurance" subsection for Member Mail Order Pharmacies will apply. Benefits are available for up to a 90-day supply. To verify that a retail Pharmacy is a participating Act 207 Pharmacy, access www.ibx.com.

Prescription Drugs Ordered From A Non-Member Mail Order Pharmacy

No benefits shall be provided for Prescription Drugs obtained by mail from a Non-Member Mail Order Pharmacy.

Refills Of Prescription Drug Orders

If the applicable Prescription Drug Order and law allow, benefits shall be provided for refills of Prescription Drugs obtained from a Member Pharmacy, a Non-Member Pharmacy, or a Member Mail Order Pharmacy according to the terms and conditions set out above. No benefits shall be provided for refills of Prescription Drugs obtained by mail from a Non-Member Mail Order Pharmacy.

Ordering And Delivery Costs

Except for benefits described herein for Prescription Drugs obtained from a Member Mail Order Pharmacy, benefits shall not be provided for costs associated with ordering and/or delivery of drugs from pharmacies. Such costs include, but are not limited to, transportation, telephone, mail, courier or parcel service costs.

Prescription Drug Benefit Period

Contract Year (twelve (12) month period beginning on Group's Anniversary Date)

Copayments And Coinsurance

Benefits for Prescription Drugs are subject to payment by a Member of the following amounts to the dispensing Pharmacy:

- Member Pharmacies:
 - \$5 per Prescription Drug Order or refill for a Low-Cost Generic Prescription Drug.
 - \$20 per Prescription Drug Order or refill for a Generic Prescription Drug.
 - \$40 per Prescription Drug Order or refill for a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
 - \$60 per Prescription Drug Order or refill for a Non-Preferred Drug Prescription Drug.
 - 50% of Allowable Charges, up to a maximum amount of \$500, per Prescription Order or refill for a Specialty Self-Injectable Prescription Drug.
- Non-Member Pharmacies:

70% of Allowable Charges per Prescription Drug Order or refill for Covered Prescription Drugs and diabetic supplies.

- Member Mail Order Pharmacies:
 - \$5 per Prescription Drug Order or refill for up to a 30 day supply of a Low-Cost Generic Prescription Drug.
 - \$10 per Prescription Drug Order or refill for a 31-90 day supply of a Low-Cost Generic Prescription Drug.
 - \$20 per Prescription Drug Order or refill for up to a 30 day supply of a Generic Prescription Drug.
 - \$40 per Prescription Drug Order or refill for a 31-90 day supply of a Generic Prescription Drug.
 - \$40 per Prescription Drug Order or refill for up to a 30 day supply of a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
 - \$80 per Prescription Drug Order or refill for a 31-90 day supply of a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
 - \$60 per Prescription Drug Order or refill for up to a 30 day supply of a Non-Preferred Drug Prescription Drug.
 - \$120 per Prescription Drug Order or refill for a 31-90 day supply of a Non-Preferred Drug Prescription Drug.

Out-of-pocket expenses incurred by a Member for Prescription Drug benefits will be included in the calculation of the Member's overall medical plan out-of-pocket limit.

The dollar amount paid by a drug manufacturer will not accumulate toward any applicable Deductible or Out-of-Pocket Limit.

For questions concerning whether a particular Prescription Drug appears on the Drug Formulary, the Member may call the Member Services telephone number referenced on the Member's Identification Card. Information about criteria and formulary exceptions can be found in the formulary guide located on the FutureScripts website. The Member may also obtain information about how to request an exception by calling Customer Service at the phone number on the Identification Card.

Administrative Procedures

Members shall comply with administrative procedures established and furnished to Members by the Health Benefit Plan and Plan Administrator to obtain the benefits described in the coverage. Such procedures shall include, but are not limited to, using forms supplied by a Member Mail Order Pharmacy to order Covered Drugs from Member Mail Order Pharmacy, and submitting to the Member Mail Order Pharmacy a brief history of Member's Prescription Drug usage.

Information about criteria and how cost-share will be determined for tier and formulary exceptions can be found in the Formulary Exception Policy. Tier exceptions can only be requested for coverage of Non-Preferred Drugs at the preferred drug tier for brand drugs or at the generic tier for generic products. The policy is available at www.ibx.com/formularyexceptionspolicy. The Member may request a hardcopy of the policy or obtain information about how to request an exception by calling Customer Service at the phone number on the Identification Card.

SECTION 3.

PRESCRIPTION DRUG EXCLUSIONS

Except as specifically provided in this Benefit Booklet, no benefits shall be provided for the following:

- Drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy;
- Drugs dispensed without a Prescription Drug Order except insulin and diabetic supplies, such as diabetic blood testing strips, lancets and glucometers;
- Prescription Drugs for which there is an equivalent that does not require a Prescription Drug Order (That is, over-the-counter medicines), whether or not prescribed by a physician. This exclusion does not apply to insulin;
- Drugs obtained through mail order Prescription Drug services of a Non-Member Mail Order Pharmacy;
- Devices of any type, even though such devices may require a Prescription Drug Order including, but not limited to, ostomy supplies, therapeutic devices, artificial appliances, hypodermic needles, syringes, vials or similar devices. This exclusion does not apply to:
 - Devices used for the treatment or maintenance of diabetic conditions and syringes used for the injection of insulin, and
 - Devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines;
- Drugs dispensed to a Member while a patient in a facility including, but not limited to, a hospital, skilled nursing facility, institution, Health Care Practitioner's office or freestanding facility;
- Drugs which are not Medically Necessary as determined by the Health Benefit Plan;
- Drugs used for Cosmetic purposes as determined by the Health Benefit Plan as not part of the Medically Necessary treatment of an illness, injury or congenital birth defect;
- Drugs which are experimental or Investigative in nature as determined by the Health Benefit Plan;
- Drugs which are not prescribed by an appropriately licensed Health Care Practitioner;
- Drugs prescribed for persons other than the requesting Employee or their Dependents;
- Injectable drugs, including infusion therapy drugs that are covered under the Contractholder's medical plan;
- Drugs for any loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation or losses sustained or expenses incurred; as a result of enemy action or act of war, whether declared or undeclared;

- Drugs for which benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- Drugs for any occupational illness or bodily injury arising out of, or in the course of, employment for which the Member has a valid and collectible benefit under any Workers' Compensation Law, Occupational Disease Law, United States Longshoremen's Act or Harbor Worker's Compensation Act, whether or not the Member claims the benefits or compensation;
- Drugs for injuries resulting from the maintenance or use of a motor vehicle if such Drugs are paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan;
- Drugs for which the Member would have no obligation to pay;
- Drugs furnished without charge to the Member;
- Drugs which have been paid under the Health Benefit Plan's Comprehensive Major Medical or Personal Choice Contract, covering this same Employer Group;
- Pharmacological therapy for weight reduction or diet agents;
- Dietary Supplements, amino acid supplements, health foods, and prescription vitamins except for pre-natal and pediatric vitamins;
- Smoking deterrent agents. This exclusion does not apply to prescribed smoking deterrent agents.
- Injectables used for the treatment of infertility when they are prescribed solely to enhance or facilitate conception;
- The administration or injection of Drugs;
- Blood and blood products;
- Intravenous drugs and intravenous solutions administered by home infusion companies;
- Drugs for a use not approved by the U.S. Food and Drug Administration;
- Drugs not approved by the Health Benefit Plan or prescribed drug amounts exceeding the eligible dosage limits established by the Health Benefit Plan.

SECTION 4.

ELIGIBILITY UNDER THE PROGRAM

Effective Date: The date the Group agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Program and described in this Benefit Booklet.

Eligible Person

The Member is eligible to be covered under this Prescription Drug Program if the Member is determined by the Group as eligible to apply for coverage and sign the Application. Eligibility shall not be affected by the Member's physical condition and determination of eligibility for the coverage by the Employer shall be final and binding.

Eligible Dependent

The Member's family is eligible for coverage (Dependent coverage) when the Member is eligible for Employee coverage. An Eligible Dependent is defined as the Member's spouse under a legally valid existing marriage, the Member's children whom the Member continuously financially support or whose coverage is the Member's responsibility under the terms of a qualified medical child support order (including stepchildren, children legally placed for adoption and the Member or the Member's spouse's legally adopted children). The limiting age for covered children is to the end of the month in which they reach age 26.

In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from an Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

A full-time student who is eligible for coverage under the coverage who is:

- A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
- A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

As proof of eligibility, the Employee must submit a form to the Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
- Notifying the Health Benefit Plan that the Dependent is no longer on active duty;
- Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after their release from active duty.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on the Member for over half of their support. The Health Benefit Plan may require proof of the Member's eligibility under the prior Health Benefit Plan's plan and also from time to time under this Prescription Drug Program.

The newborn child(ren) of any Member shall be entitled to the benefits provided by the Health Benefit Plan from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, the Member must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, the Member must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under this coverage on the date the Dependent is acquired provided that the Member applies to the Health Benefit Plan for addition of the Dependent within 31 days after the Dependent is acquired and the Member makes timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after the Member's Application is accepted by the Health Benefit Plan.

A Dependent child of a custodial parent covered under this coverage may be enrolled under the terms of a qualified release or court order, as required by law.

No Dependent may be eligible for coverage as a Dependent of more than one Employee of the Enrolled Group. No individual may be eligible for coverage hereunder as an Employee and as a Dependent of an Employee at the same time.

SECTION 5.

GENERAL INFORMATION

Benefits To Which You Are Entitled

The liability of the Health Benefit Plan is limited to the benefits specified in this Benefit Booklet and as set forth in the Group Program document. No person other than a Member is entitled to receive benefits as provided under this Program. Benefits for Covered Services specified under the Program will be provided only for services and supplies that are rendered by a provider specified in the *Important Definitions* section of this Benefit Booklet.

Termination Of Coverage At Termination Of Employment Or Membership In The Group

When a Member ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Health Benefit Plan before the Health Benefit Plan receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Contractholder notified the Health Benefit Plan of such termination.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Pennsylvania Act 62 Of 2009 (Mini-COBRA)

This subsection, and the requirements of Mini-COBRA continuation, applies to groups consisting of two to 19 Employees.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify that person for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- A covered Employee;
- The Employee's spouse; or
- The Employee's Dependent child.

In addition, any child born to or placed for adoption with the Employee during Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Program during Mini-COBRA continuation, other than a child born to or placed for adoption with the Employee during Mini-COBRA continuation, will not be a qualified beneficiary.

- If An Employee Terminates Employment or Has a Reduction of Work Hours: If the Employee's group benefits end due to the Employee's termination of employment or reduction of work hours, the Employee may be eligible to continue such benefits for up to nine months, if:
 - The Employee's termination of employment was not due to gross misconduct;
 - The Employee is not eligible for coverage under Medicare;
 - The Employee verifies that the Employee is not eligible for group health benefits as an eligible dependent; and
 - The Employee is not eligible for group health benefits with any other carrier.

The continuation will cover the Employee and any other qualified beneficiary who loses coverage because of the Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the "When Continuation Ends" paragraph of this subsection.

- The Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
 - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
 - The Employee's death;
 - The Employee's divorce or legal separation from an eligible dependent;
 - The Employee becomes eligible for benefits under Social Security;
 - The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;
 - Commencement of Employer's bankruptcy proceedings.

The notice must be given to the Employee, the plan administrator and the Health Benefit Plan no later than 30 days of any of these events.

- The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Employer.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If an Employee Dies: If the covered Employee dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.
- If an Employee's Marriage Ends: If the Employee's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If a Dependent Loses Eligibility: If the Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.
- Election of Continuation: To continue the qualified beneficiary's group health benefits, the qualified beneficiary must give the plan administrator written notice that the qualified beneficiary elects to continue benefits under the Program. This must be done within 30 days of the date a qualified beneficiary receives notice of the qualified beneficiary's continuation rights from the plan administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Health Benefit Plan of the qualified beneficiary's election of continuation within 14 days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the plan administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the plan administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

- Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.
- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program ends on the first to occur of the following:
 - With respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - With respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - With respect to the Employee's Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
 - The date coverage under this Program ends;
 - The end of the period for which the last premium payment is made;

- The date the qualified beneficiary becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- The date the Employee and/or eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS PROGRAM ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BENEFIT BOOKLET.

THE HEALTH BENEFIT PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE PROGRAM OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member for over half of their support, the Member may apply to the Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 26.

The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over the limiting age and joining the Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

When The Member Files A Claim

When the Member needs to file a claim, the Member should fill out the claim form and return it with the Member's itemized bills to QCC Insurance Company no later than 20 days after the Member's Prescription Drugs are provided to the Member. The claim should include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the Prescription Drugs are rendered.

If it was not possible to file the claim within the 20-day period, the Member's benefits will not be reduced, but in no event will the Health Benefit Plan be required to accept the claim more than two years after the end of the Benefit Period in which the Prescription Drugs were rendered.

Release Of Information

Each Member agrees that any person or entity having information relating to an illness or injury, for which benefits are claimed under this Program, may furnish to the Health Benefit Plan any information (including copies of records relating to the illness or injury).

In addition, the Health Benefit Plan may furnish similar information to other entities providing similar benefits at their request.

The Health Benefit Plan shall provide to the Contractholder at the Contractholder's request certain information regarding claims and charges submitted to the Health Benefit Plan in a mutually acceptable format. The parties understand that any information provided to the Contractholder will be adjusted by the Health Benefit Plan to prevent the disclosure of the identity of any Member or other patient treated by said providers. The Contractholder shall reimburse the Health Benefit Plan for the actual costs of preparing and providing said information.

The Health Benefit Plan may also furnish membership and/or coverage information to affiliated Health Benefit Plans or other entities for the purpose of claims processing or facilitating patient care.

Limitation Of Actions

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the date Covered Drugs are dispensed.

Claim Forms

The Health Benefit Plan will furnish to the Member making the claim, or to the Contractholder, for delivery to such Member, such forms as are required for filing proof of loss.

Member/Provider Relationship

- The choice of a Provider is solely the Member's.
- The Health Benefit Plan does not furnish Covered Drugs but only makes payment for Covered Drugs received by Members. The Health Benefit Plan is not liable for any act or omission of any Provider. The Health Benefit Plan has no responsibility for a Provider's failure or refusal to render Covered Drugs to a Member.

Agency Relationships

The Contractholder is the agent of the Member, not the Health Benefit Plan.

Identification Cards And Benefit Booklets/Certificates

The Health Benefit Plan will provide Identification Cards to Members or to the Contractholder, depending on the direction of the Group. The Health Benefit Plan will also provide to each Member of an Enrolled Group a Benefit Booklet describing the benefits provided under the Group Contract.

Applicable Law

The Group Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

Member Rights

A Member shall have no rights or privileges as to the benefits provided under this Program except as specifically provided herein.

Assignment

The Group Contract and the benefits hereunder are not assignable by the Contractholder or any Member in whole or in part to any person, Pharmacy or other entity, except where required by law in the case of a custodial parent of a Dependent covered under the Group Contract.

Notice

Any notice required under the Group Contract must be in writing. Notice given to a Member will be given to the Member in care of the Contractholder, or sent to the Member's last address furnished to the Health Benefit Plan by the Contractholder. The Contractholder, the Health Benefit Plan, or a Member may, by written notice, indicate a new address for giving notice.

Subrogation and Reimbursement Rights

By accepting benefits for Allowable Charges, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

- **Subrogation Rights**

Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

- **Reimbursement Rights**

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The Health Benefit Plan has a right to full reimbursement.

- Lien
 By accepting benefits for Allowable Charges from the Health Benefit Plan, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan is reimbursed in full.

- Constructive Trust
 If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Health Benefit Plan to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan.

 - These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
 - These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
 - These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
 - The Health Benefit Plan is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
 - The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing. The recovery rights of the Health Benefit Plan will not be reduced by the "common fund" doctrine.
 - In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
 - These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.

- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.
- **Obligations of Member**
 - Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
 - Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
 - Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
 - Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
 - Avoid taking any action that may prejudice or harm the Health Benefit Plan ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
 - Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
 - Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan paid benefits for an injury or illness.
 - All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

Professional Judgment

A Pharmacist shall not be required to fill any Prescription Drug Order which in his professional judgment should not be filled.

Delivery Of Prescription Drugs

The Health Benefit Plan shall not be responsible for delay in the delivery of a Prescription Drug.

Limitations Of Health Benefit Plan Liability

The Health Benefit Plan shall not be liable for injuries or damage resulting from acts or omissions of any Health Benefit Plan officer or Member or of any provider or other person furnishing services or supplies to the Member; nor shall the Health Benefit Plan be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

Liability For Prescription Drugs

- The Health Benefit Plan shall not be liable for any claims or demand arising out of, on in connection with, the manufacturing, compounding, dispensing or use of any drug covered under this Program.
- The Health Benefit Plan shall not be liable for any abuse, physical dependency, or overdose which is the result of the Member's misuse or mismanagement of a Prescription Drug.
- If the Health Benefit Plan determines Prescription Drug usage by the Member or the Member's Eligible Dependents appears to exceed usage generally considered appropriate under the circumstances, the Health Benefit Plan shall have the right to direct the Member or the Member's Eligible Dependents to one Pharmacy for all future Prescription Drug Covered Services.
- In certain cases, the Health Benefit Plan may determine that the use of certain Prescription Drugs for a Member's medical condition requires pre-certification for Medical Necessity. The Health Benefit Plan also reserves the right to establish eligible dosage limits of certain Prescription Drugs covered by the Health Benefit Plan.

Payment Of Providers

A Pharmacy Benefits Manager (PBM), which is affiliated with the Health Benefit Plan, administers our Prescription Drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The Health Benefit Plan anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, Prescription Drugs are subject to a Member's cost-sharing, including Copayment, Coinsurance and Deductible, as applicable.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, or to the procedures required for obtaining benefits for Covered Services under this Program (For Example, obtaining Precertification, use of Participating Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan may on a selective basis, waive certain procedural requirements of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Health Benefit Plan shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Health Benefit Plan nor the Health Benefit Plan providers shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances, as recognized in the community, and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot; or
- Civil insurrection.

SECTION 6.

RESOLVING PROBLEMS (COMPLAINTS/APPEALS)

Member Complaint Process

The Plan has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Plan at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Plan is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within 30 days.

Member Appeal Process

- Filing an Appeal.

The Plan maintains procedures for the resolution of Member appeals. Internal Appeals may be filed within 180 days of the receipt of a decision from the Plan stating an adverse benefit determination. An Appeal occurs when the Member, after obtaining the Member's authorization, either the provider or another authorized representative requests a change of a previous decision made by the Plan by following the procedures described here. (In order to authorize someone else to be the Member's representative for the Appeal, the Member must complete a valid authorization form. The Member should contact the Plan as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an Appeal by calling or writing to the Plan, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820

Toll Free Phone: 1-888-671-5276
Toll Free Fax: 1-888-671-5274
Philadelphia Fax: 215-988-6558

The Member or designee is entitled to a full and fair review. Specifically, at all appeal levels the Member or designee may submit additional information pertaining to the case, to the Plan. The Member or designee may specify the remedy or corrective action being sought. At the Member's request, the Plan will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Plan will automatically provide the Member or designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or designee at no charge.

The Plan will not terminate or reduce an ongoing course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.

Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Member or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.

▪ Types of Appeals

Following are the two types of Appeals and the issues they address:

- Medical Necessity Appeal - An Appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Plan to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include Appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services. A matched specialist is the decision maker for a Medical Necessity Standard (appeals for non-urgent care) Internal Appeal. A matched specialist is a licensed physician, psychologist or other health care professional in the same or similar specialty that typically manages the care under review. This individual has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination.
- Administrative Appeal - A dispute or objection by a Member regarding the following: operations or management policies of a health care plan, non-covered services, coverage limitations, participating or non-participating provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions), that has not been resolved by the health care plan. An employee of the Plan is the decision maker for an Administrative Appeal. This individual has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination.

- Internal Standard Appeals Review:

- Pre-service Appeal - An Appeal for benefits that, under the terms of this Contract, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available. For a standard Pre-Service appeal, a maximum of 30 days is available for the one level of internal appeal.
- Post-service Appeal - An Appeal for benefits that is not Pre-service Appeal. (Post-service Appeals concerning claims for services that the Member has already obtained do not qualify for review as Expedited/Urgent appeals.) For a standard Post-Service appeal, a maximum of 60 days is available for the one level of internal appeal.

The decision of the Plan is sent to the Member or designee in writing within the timeframe noted above.

- Internal Expedited/Urgent Appeals Review:

- Expedited/Urgent Appeal - An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

The appeals review process for an urgent/expedited appeal mirrors the process described above under the section entitled "Types of Appeal".

The expedited review is completed promptly based on the Member's health condition, but no later than 72 hours after receipt of the expedited appeal request by the Plan. Within 72 hours after receipt of the expedited appeal, the Plan notifies the Member or designee by telephone of the determination. The determination is sent in writing within 72 hours after the Member or designee has received the verbal notification.

For urgent care appeals, the Member or designee may also file an expedited external medical necessity appeal at the same time as filing an internal expedited medical necessity appeal.

If not satisfied with the standard or expedited decision from the Plan, the Member or designee has the right to initiate an external appeal as described below.

- External Appeals Process

The external appeals process for both standard and expedited/urgent appeals is coordinated by the Pennsylvania Department of Health (DOH).

- External Standard Appeal Review (Medical Necessity or Administrative adverse benefit determinations):

The Member or designee may request an external appeal review by a Certified External Review Entity (CRE) by calling or writing to the Plan within 180 calendar days of receipt of the internal appeal decision letter. To request an external appeal review by a CRE, the Member may call or write to the Member Appeals Department at the phone number or address listed above.

The Member is not required to pay any of the costs associated with the external review. The Member or designee is sent written confirmation of receipt of the external appeal request from the Plan within five business days of receipt of the request. The Plan contacts the Pennsylvania Department of Health to request assignment of a CRE to review the appeal. Within two business days of the Plan's receipt of the assignment from the Department of Health, the Plan notifies the Member designee of the name, address and telephone number of the external agency assigned to review the appeal. If the Member or designee feels that a conflict of interest exists, they may call or write the contact person listed on the acknowledgement letter from the Plan no later than seven business days from receipt of the acknowledgment letter from the Plan. Within 15 calendar days of receipt of the request, the Plan sends the member or designee a copy of all documents forwarded to the CRE. These documents include copies of all information submitted for the internal appeal process, as well as any additional information that the member, designee, or the Plan may submit. The Member or designee may submit additional information for consideration by the CRE within 15 calendar days of the request for an external appeal.

The Plan does not attempt to interfere with the CRE's proceedings or appeals decisions. The CRE conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal process.

The CRE makes its final decision within 60 calendar days of receipt of the request to the Plan and simultaneously issues its decision in writing to the Member or designee and to the Plan.

– External Expedited/Urgent Appeal Review:

The Member or designee may request an external review by a Certified External Review Entity (CRE) by calling or writing to the Plan within two calendar days of receipt of the internal appeal decision letter.

The CRE makes a decision and simultaneously notifies the Member or designee, and the Plan in writing within two business days of receipt of all relevant documentation. The decision letter identifies the assigned CRE by name and the qualifications of the reviewer.

– CRE Decisions:

For both standard and expedited external appeals, if the decision of the CRE is that the services are eligible under the terms of the Plan, the Plan authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of the appeal. The Plan implements the CRE's decision within the time period, if any, specified by the CRE. The decision is binding on the Plan. The external grievance decision may be appealed to a court of competent jurisdiction by the Plan or designee within 60 days of the decision of the external agency.

Changes in Members Appeals Processes. Please note that the Member Appeal processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Appeals processes, or to reflect other decisions regarding the administration of Member Appeal processes for this Contract.

SECTION 7.

IMPORTANT DEFINITIONS

For the purpose of the Program, the terms below have the following meaning:

Accredited Educational Institution

A publicly or privately operated academic institution of higher learning which:

- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
 - A diploma;
 - A degree; or
 - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
 - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to Colleges and Universities; and Technical or specialized schools.

Allowable Charges

For services rendered by a Member Pharmacy, the amount that the Health Benefit Plan has negotiated to pay the Member Pharmacy as total reimbursement for Prescription Drugs, and for services rendered by a Non-Member Pharmacy, the lesser of the Non-Member Pharmacy's charges for the Covered Drug, or 150% of Average Wholesale Price for the same Covered Drug.

Applicant and Employee/Member

Applicant and Employee/Member shall mean you, the individual who applies for coverage which the Health Benefit Plan has entered into with the Employer/Group. For Purposes of this Program, Employee and Member are interchangeable terms.

Application and Application Card

The request, either written or via electronic transfer, of the Applicant for benefits under the Program, set forth in a format approved by the Health Benefit Plan, whether such written request was made under a prior Program that has been superseded by this Program, or under this Program.

Authorized Generics

Brand Name Drugs that are marketed without the brand name on its label. An Authorized Generic may be marketed by the Brand Name Drug company, or another company with the brand company's permission. Unlike a standard Generic Drug, the Authorized Generic is not approved by the Food and Drug Administration (FDA) abbreviated new drug application process (ANDA). For cost sharing purposes Authorized Generics are treated as Brand Name Drugs.

Brand Name or Brand Name Drug

A Prescription Drug approved by the U.S. Food and Drug Administration (FDA) through the new drug application (NDA) process and in compliance with applicable state law and regulations. For purposes of this Program, the term "Brand Name Drug" shall also include Authorized

Generics and devices which includes spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

Certified External Review Entity (CRE)

An entity qualified by applicable licensure, certification and/or accreditation to act as the independent decision maker for external Medical Necessity and administrative appeals for issues related to an adverse benefit determination. The Pennsylvania Department of Health arranges for the availability of CREs and assigns them to review external medical necessity and administrative appeals. CREs are not corporate affiliates of the Health Benefit Plan.

Chronic Drugs

A Covered Drug recognized by the Health Benefit Plan for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis. For purposes of the Program, the term "Chronic Drugs" shall also mean the following diabetic supplies that may not require a Prescription Drug Order:

- Insulin syringes;
- Diabetic blood testing strips; and
- Lancets.

Coinsurance

A percentage of Allowable Charges which must be paid by the Member toward the cost for filling or refilling a Prescription Drug Order for Prescription Drugs.

Contract

The Group Policy of Prescription Drug benefits, including the Group Application, riders and/or endorsements, if any, between the Health Benefit Plan and the Contractholder, also referred to as the Group Contract.

Contractholder

Any individual, corporation or other entity who, as the representative of an enrolled group of Employees (Members) and as Agent for the Members is acceptable to the Health Benefit Plan. The Contractholder has agreed to pay the charges payable under the Contract to the Health Benefit Plan and to receive any information from the Health Benefit Plan on behalf of the Applicants.

Copayment

A specified amount which must be paid by the Member toward the cost for filling or refilling a Prescription Drug Order for Prescription Drugs.

Cosmetic Drug or Drugs Used For Cosmetic Purposes

Drugs which are determined by the Health Benefit Plan to be:

- For other than the treatment of illness, injuries, congenital birth defect or restoration of physiological function; or
- For cleansing, beautifying, promoting attractiveness or altering the appearance of any part of the human body.

Covered Drug

Prescription Drugs, including Self-Administered Prescription Drugs, which are:

- Appearing on the Drug Formulary, or where an exception has been granted
- Prescribed for a Member by a Health Care Practitioner who is appropriately licensed to

- prescribe Drugs;
- Prescribed for a use that has been approved by the Federal Food and Drug Administration; and
- Medically Necessary, as determined by the Health Benefit Plan.

Insulin shall be considered a Covered Drug where Medically Necessary.

Deductible

A specified amount of Allowable Charges, usually expressed in dollars, that must be Incurred by a Member before the Health Benefit Plan will assume any liability for all or part of the remaining Allowable Charges.

Dentist

A person who is a Doctor of Dentistry Science (DDS) or a Doctor of Dental Medicine (D.M.D.), licensed and legally entitled to practice dentistry and dispense drugs.

Dependent

- The Applicant's spouse under a legally valid existing marriage.
- The children, (including stepchildren, children legally placed for adoption, and legally adopted children of the Applicant or the Applicant's spouse) who are continuously financially supported by the Applicant, or whose coverage is the responsibility of the Applicant under the terms of a qualified release or court order. The limiting age for covered children is the first of the month following the month in which they reach age 26. The limiting age for covered children is to the end of the month in which they reach age 26.

Drug

A substance which is:

- Recognized in the *Approved Drug Products with Therapeutic Equivalent and Evaluations* (The FDA Orange Book);
- Intended for use in the treatment of disease or injury; and
- Not a device or a component, part or accessory of a device.

Drug Formulary

A list of drugs, or Covered Drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other practitioners to prescribe all Medically Necessary treatment of a Member's condition.

Effective Date

According to the *Eligibility Under The Program* section, the date on which the Member's coverage begins.

Employee/Member

An individual of the Group who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

Experimental Drug or Investigative Drug

Any Drug or drug usage device or supply which the Health Benefit Plan, relying on the advice of the general medical community, which includes but is not limited to medical consultants, medical journals and/or governmental regulations, does not accept as standard medical

treatment of the condition being treated, or any such Drug or drug usage device or supply requiring federal or other governmental agency approval, which approval has not been granted at the time services were rendered.

Family Coverage

Coverage for the Employee and one or more of the Employee's Dependents.

Generic Drug

Any form of a particular Prescription Drug which is:

- Sold by a manufacturer other than the original patent holder;
- Approved by the U.S. Food and Drug Administration as being generically equivalent through the FDA abbreviated new drug application (ANDA) process; and
- In compliance with applicable state laws and regulations.

Group or (Enrolled Group)

A group of Employees which has been accepted by the Health Benefit Plan, consisting of all those Applicants whose charges are remitted together with all the Employees and Dependents, listed on the Application Cards or amendments thereof, who have been accepted by the Health Benefit Plan.

Health Care Practitioner

A Physician, Dentist, podiatrist, nurse practitioner or other person licensed, registered and certified as required by law to prescribe Drugs in the course of his professional practice.

Identification Card

The currently effective card issued to the Member by the Health Benefit Plan.

Immediate Family

The Employee's:

- Spouse;
- Parent;
- Child, stepchild;
- Brother, sister;
- Mother-in-law, father-in-law;
- Sister-in-law, brother-in-law;
- Daughter-in-law, son-in-law.

Incurred

A charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

Medically Necessary (Medical Necessity)

Shall mean:

- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of:
 - Preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:

- In accordance with generally accepted standards of medical practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
 - Not primarily for the convenience of the patient, Physician, or other health care provider; and
 - Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on:
 - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations; and
 - The views of Physicians practicing in relevant clinical areas; and
 - Any other relevant factors.

Member Mail Order Pharmacy

A Pharmacy which has entered into an agreement to provide the Health Benefit Plan's Members with the mail order prescription drug services described in the Program.

Member Pharmacy

A Pharmacy which has entered into an agreement to provide the Health Benefit Plan's Members with the prescription drug services described in the Program other than mail order prescription drug services.

Non-Member Mail Order Pharmacy

Any Pharmacy which has not entered into an agreement to provide the Health Benefit Plan's Members with mail order prescription drug services.

Non-Member Pharmacy

A Pharmacy which has not entered into an agreement to provide any prescription drug services to the Health Benefit Plan's Members.

Non-Preferred Drug

These drugs generally have one or more generic alternatives or preferred brand options within the same drug class.

Pharmacist

A person who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

Pharmacy

Any establishment which is registered and licensed as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

Pharmacy Benefits Manager (PBM)

An entity that has entered into a contract with the Health Benefit Plan to perform prescription drug claims processing and related administrative services, and has agreed to arrange for the provision of pharmacy services to the Health Benefit Plan's Members.

Physician

A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery and dispense Drugs.

Preferred Brand

These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

Prescription Drug

- Any medication which by federal and/or state laws may be dispensed with a Prescription Drug Order; and
- Insulin.

The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Health Benefit Plan.

Prescription Drug Order

The request in accordance with applicable laws and regulations for medication issued by a Health Care Practitioner who is licensed to prescribe Drugs.

Self-Administered Prescription Drug

A Prescription Drug that can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:

- Oral Drugs;
- Self-Injectable Drugs;
- Inhaled Drugs; and
- Topical Drugs.

Self-Injectable Prescription Drug (Self-Injectable Drug)

A Prescription Drug that:

- Is introduced into a muscle or under the skin by means of a syringe and needle; and
- Can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required.



The Summary of Benefits and [Coverage](#) (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your [coverage](#), or to get a copy of the complete terms of [coverage](#), at www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For In-network Provider \$1,500 person / \$3,000 family; for Out-of-network Provider \$5,000 person / \$10,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , Primary care services, Specialist services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For In-network Provider \$7,350 person / \$14,700 family; for Out-of-network Provider \$10,000 person / \$20,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copayment (copay) /visit, Deductible does not apply	50%	None
	Specialist visit	\$40 copay /visit, Deductible does not apply	50%	None
	Preventive care/screening /immunization	No Charge, Deductible does not apply	50%, Deductible does not apply	Age and frequency schedules may apply. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: \$40 copay /Visit. Deductible does not apply. Blood Work: \$40 copay /Visit Freestanding facilities; \$80 copay /Visit Hospital-based facilities. Deductible does not apply.	50%	None
	Imaging (CT/PET scans, MRIs)	\$80 copay /test, Deductible does not apply	50%	Pre-certification required for certain services. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/ffm/foarmulary5v	Generic drugs	\$20 copay /prescription fill (1-30 days supply/Retail & Mail); \$40 copay /prescription fill (31-90 days supply/Mail)	70%	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. Self-administered specialty drugs under pharmacy benefit limited to 30 days supply and may require use of preferred specialty pharmacy. Low-Cost Generics available at a reduced cost. *See section(s) prescription drug.
	Preferred brand	\$40 copay /prescription fill (1-30 days supply/Retail & Mail); \$80 copay /prescription fill (31-90/Mail)	70%	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. Self-administered specialty drugs under pharmacy benefit limited to 30 days supply and may require use of preferred specialty pharmacy. *See section(s) prescription drug.
	Non-preferred drugs	\$60 copay /prescription fill (1-30 days supply/Retail & Mail); \$120 copay /prescription fill (31-90/Mail)	70%	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. Self-administered specialty drugs under pharmacy benefit limited to 30 days supply and may require use of preferred specialty pharmacy. *See section(s) prescription drug.

*For more information about limitations and exceptions, see [plan](#) or policy document at www.ibx.com/LGBooklet

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
	Specialty drugs	50% Coinsurance (co-ins) with a Maximum (max) member payment of \$500/ prescription fill (1-30 days supply)	Not Covered	This applies to self-administered specialty drugs covered under the prescription drug plan . Limited to a maximum 30 days supply. Prior authorization and/or additional dispensing limits may apply. Other specialty injectables and infusion therapy drugs may be covered under your medical benefits. *See section(s) prescription drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	50%	Pre-certification may be required. *See section General Information.20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fees	No Charge	50%	Pre-certification may be required. *See section General Information.20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need immediate medical attention	Emergency room care	\$250 copay /visit	Covered at in-network level	None
	Emergency medical transportation	No Charge	Covered at in-network level	None
	Urgent care	\$85 copay /visit, Deductible does not apply	50%	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fees	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit, Deductible does not apply	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Inpatient services	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you are pregnant	Office visits	No Charge, Deductible does not apply	50%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.

*For more information about limitations and exceptions, see [plan](#) or policy document at www.ibx.com/LGBooklet

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
	Childbirth/delivery professional services	No Charge	50%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery facility services	No Charge	50%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
If you need help recovering or have other special health needs	Home health care	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. 60 visits/ benefit period, combined in and out-of-network.
	Rehabilitation services	\$40 copay /visit, Deductible does not apply	50%	20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. All visit limits combined in and out-of-network.
	Habilitation services	\$40 copay /visit, Deductible does not apply	50%	20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. All visit limits combined in and out-of-network.
	Skilled nursing care	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. 120 visits/ benefit period. Visit limits combined in and out-of-network.
	Durable medical equipment	No Charge	50%	Pre-certification required for selected items. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network or Bluecard services.
	Hospice services	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None

*For more information about limitations and exceptions, see [plan](#) or policy document at www.ibx.com/LGBooklet

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

Bariatric Surgery	Cosmetic Surgery	Dental care (adult)
Hearing aids	Infertility treatment	Long-term care
Private-duty nursing	Routine Eye care (adult)	Routine foot care
Weight loss programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

Acupuncture	Chiropractic Care	Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
-------------	-------------------	--

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your [coverage](#) after it ends. To contact the [plan](#) at 1-800-ASK-BLUE (TTY:711) or the contact information for those agencies is: For group health [coverage](#) subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health [plans](#), contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church [plans](#) are not covered by the Federal COBRA continuation [coverage](#) rules. If the [coverage](#) is insured, you should contact your State Insurance regulator regarding possible rights to continuation [coverage](#) under State law. Other [coverage](#) options may be available to you too, including buying individual insurance [coverage](#) through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Pennsylvania Insurance Department - 1-877-881-6388 - <http://www.insurance.pa.gov/Consumers>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health [coverage](#) for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these [coverage](#) examples are based on self-only [coverage](#).

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	100%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing

Deductibles	\$1,500
Copayments	\$40
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$1,000
The total Peg would pay is	\$2,540

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	100%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing

Deductibles	\$0
Copayments	\$2,100
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$200
The total Joe would pay is	\$2,300

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	100%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing

Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$30
The total Mia would pay is	\$1,730

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Employer and may be changed or ended without Your consent or notice to You.

Employer: Insight PA Cyber Charter School

Group Policy Number: TS 05956371-G

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):
For General Information 1-800-275-4638

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If you are not satisfied with your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if you elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under your Certificate will not be covered.

For New Hampshire Residents: 30 Day Right to Examine Certificate. Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

GCERT2000

fp

All Active Full-Time Employees
NB 01/07/2019

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-800-275-4638

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-800-275-4638

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICE FOR RESIDENTS OF TEXAS

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

If You reside in Texas, note the following Procedures for Dental Claims will be followed:

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will notify You acknowledging receipt of Your claim, commence with any investigation, and request any additional information within 15 days of receipt of Your claim.

MetLife will notify You in writing of the acceptance or rejection of Your claim within 15 business days of receipt of all information needed to process Your claim.

If MetLife cannot accept or reject Your claim within 15 business days after receipt of all information, MetLife will notify You within 15 business days stating the reason why we require an extension. If an extension is requested, We will notify You of our decision to approve or deny Your claim within 45 days. Upon notification of approval, Your claim will be paid within 5 business days.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

NOTICE FOR RESIDENTS OF TEXAS

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

NOTICE FOR RESIDENTS OF TEXAS

The exclusion of services which are primarily cosmetic will not apply to the treatment or correction of a congenital defect of a newborn child.

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

Reasonable and Customary Charges for Out-of-Network services will not be based less than an 80th percentile of the dental charges.

Reasonable Access to an In-Network Dentist

If You do not have an In-Network Dentist within 50 miles of Your legal residence, We will reimburse You for the cost of Covered Services and materials provided by an Out-of-Network Dentist at the same benefit level as an In-Network Dentist.

Coordination of Benefits or Non-Duplication of Benefits with a Secondary Plan:

If This Plan is Secondary, This Plan will determine benefits as if the services were obtained from This Plan's In-Network provider under the following circumstances:

- the Primary Plan does not provide benefits through a provider network;
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services through a provider in the Primary plan's network who is not in This Plan's network; or
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services from a provider that is not part of the provider network of the Primary Plan or This Plan because no provider in the Primary Plan's provider network or This Plan's network is able to meet the particular health need of the covered person.

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the

NOTICE FOR RESIDENTS OF ALASKA

requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Within 30 days after We receive Proof of Your claim, We will approve and pay the claim or We will deny the claim. If We deny the claim, We will provide You with the basis of Our denial or the specific additional information that We need to adjudicate Your claim. If We request additional information, We will approve and pay the claim or We will deny the claim within 15 days after We receive the additional information. If the claim is approved and not paid within the time period provided, the claim will accrue at an interest rate of 15 percent per year until the claim is paid.

Appealing the Initial Determination

If MetLife denies Your claim, You may appeal the denial. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision, or as soon as reasonably possible for situations in which You cannot reasonably meet the deadline. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. Your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim.

MetLife will notify You in writing of its final decision within 18 days after MetLife's receipt of Your written request for review.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

NOTICE FOR RESIDENTS OF ALASKA

Second Level Appeal

If You disagree with the response to the initial appeal of the denied claim, You have the right to a second level appeal. We shall communicate Our final determination to You within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the You shall include the specific reasons for the determination.

External Appeal

If You disagree with the response to the second appeal of the denied claim, You have the right to an external appeal. We will communicate the decision of the external appeal agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer's decision. Decisions made by an external appeal agency are binding on Us and You unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by You or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

We have the right to recover any amount that is determined to be an overpayment, within 180 days from the date of service, whether for services received by You or Your Dependents.

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Insurance benefits is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us.

How We Recover Overpayments

We may recover the overpayment, within 180 days from the date of service, from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment within 180 days from the date of service, from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

**DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357**

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for dental insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

“Domestic Partner means each of two people, one of whom is an employee of the Employer, a resident of California and who have registered as domestic partners or members of a civil union with the California or another government recognized by California as having similar requirements.

For purposes of determining who may become a Covered Person, the term does not include any person who:

- is in the military of any country or subdivision of a country;
- is insured under the Group Policy as an employee.”

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term Spouse appears, except in the definition of Spouse, it shall be replaced by Spouse or Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Employer and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-800-275-4638**

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

The following provisions are required by Massachusetts law.

Translation Services

Translation services are available by calling 1-800-638-3368. We shall make available upon request interpreter and translation services related to administrative procedures by calling member services.

منقوم عند الطلب بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية وذلك بالاتصال بخدمات العملاء.

យើងនឹងមានផ្តល់អ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង វិធីចាត់ចែងការ ពាមការស្នើ ហោយទូរស័ព្ទទៅកន្លែងបម្រើសមាជិក ។

我們提供協助辦理行政手續的翻譯服務，您若需要翻譯人員，請電洽會員服務處。

Nous assurerons sur demande, les services d'interprétariat et de traduction en connexion avec les procédures administratives, en appelant les services aux membres.

Θα διαθέσουμε μετά από αίτηση υπηρεσίες διερμηνεία και μεταφραστική σχετικά με διοικητικές διαδικασίες ερχόμενοι σε επαφή με τις υπηρεσίες μελών.

Si w rele depatman sèvis kliyan an, epi w mande sèvis entèprèt ak tradiksyon pou pwosede administratif, sèvis la ap disponib pou w.

A richiesta metteremo a disposizione servizi di interpretariato e traduzione riguardo le procedure amministrative. Telefonare all'ufficio di Assistenza soci.

ຖ້າທ່ານຮ້ອງຂໍ, ພວກເຮົາຈະຈັດຕັ້ງບາງບາງສາຂາຂອງພວກເຮົາໃຫ້ກັບທ່ານ ອາດຈະເຮັດວຽກຮ່ວມກັນກັບຄອບຄົວທ່ານ ໂດຍທ່ານສາມາດໂທສູນບໍລິການພວກເຮົາໄດ້.

Disponibilizaremos, a seu pedido, os serviços de um(a) tradutor(a)/intérprete para os procedimentos administrativos, contactando os serviços para membros.

По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами, если Вы позволите в отдел по обслуживанию членов.

Si usted lo solicita, pondremos a su disposición servicios de interpretación y traducción para asistirle en los procedimientos administrativos. Si necesita estos servicios, comuníquese con servicios a los miembros.

NOTICE FOR MASSACHUSETTS RESIDENTS (Continued)

The following provisions are required by Massachusetts law.

Summary of Utilization Review Procedures

MetLife reviews claims for evidence of need for certain dental procedures. These reviews are conducted by licensed dentists. If there is no evidence of need MetLife will deny benefits for a claim. MetLife also reviews claims to determine whether there exists a less costly treatment for a dental condition that is generally considered effective to treat the condition. If a less costly alternative treatment exists, MetLife will determine benefits based on the alternative treatment. If you want to determine the status of any such claim review, you can call MetLife at 1-800-275-4638.

Summary of Quality Assurance Programs

MetLife performs a check on certain credentials of any dentist applying to participate in MetLife's Participating Dentist Program (PDP). If the credentials do not meet MetLife's standards, for example if a dentist does not have a valid license, the dentist will not be permitted to participate in the PDP. MetLife does not interfere with the traditional relationship between PDP dentists and their patients, or any determination between the patient and dentist as to what the appropriate dental treatment may be. MetLife dental plans also allow you to choose between any dentist, whether they participate in the PDP or not. Therefore you should choose your dentist carefully, and you are responsible to be sure that your dentist delivers quality dental care.

Involuntary Disenrollment Rate

The involuntary disenrollment rate among insureds of MetLife is 0.

NOTICE FOR RESIDENTS OF MASSACHUSETTS

CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Dental Insurance ends because:
 - You cease to be in an Eligible Class; or
 - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Dental Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Dental Insurance for Your former Spouse that would otherwise end may be continued.

To continue Dental insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Dental Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Dental Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Dental Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all employees;
- this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Dental Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Dental Insurance;
- the amount of premium payment that is required to continue Your Dental Insurance;
- the manner in which You must request to continue Your Dental Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Dental Insurance may include:

- any amount that You contributed for Your Dental Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Dental Insurance, You must:

- send a written request to continue Your Dental Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Dental Insurance; or
- the date You become eligible for coverage under any other group dental coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (Continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all Dependents;
- this Dental Insurance is changed, for the class of employees to which You belong, to end Dental Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Dental Insurance for Your Dependents ends because You fail to pay a required premium.

If Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Dental Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Dental Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Dental Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Dental Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Dental Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Dental Insurance for Your Dependents may include:

- any amount that You contributed for Your Dental Insurance before it ended; and
- any amount the Employer paid.

To continue Dental Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Dental Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Dental Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (Continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Dental Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Dental Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group dental coverage.

NOTICE FOR RESIDENTS OF NORTH CAROLINA

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE FOR RESIDENTS OF ALL STATES

MetLife complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. MetLife will not deny or limit coverage based on an individual's sex assigned at birth or gender identity. MetLife will not deny or limit coverage related to a specific health service that is related to gender transition if such denial or limitation results in discriminating against a transgender individual.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Dental Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - o \$500,000 in death benefits
 - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$500,000 in long-term care insurance benefits
 - o \$500,000 in disability income insurance benefits
 - o \$500,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1-877-310-6560 - toll-free
1-804-371-9032 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)
3600 West Broad St
Suite 216
Richmond, VA 23230
1-800-955-1819

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

If You have any questions regarding an appeal or grievance concerning the dental services that You have been provided that have not been satisfactorily addressed by this Dental Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

You may contact the Virginia Office of the Managed Care Ombudsman either by dialing toll free at (877) 310-6560, or locally at (804) 371-9032, via the internet at Web address www.scc.virginia.gov, email at ombudsman@scc.virginia.gov, or mail to:

The Office of the Managed Care Ombudsman
Bureau of Insurance, P.O. Box 1157
Richmond, VA 23218

NOTICE FOR RESIDENTS OF WEST VIRGINIA

FREE LOOK PERIOD:

If You are not satisfied with Your certificate, You may return it to Us within 10 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 10 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

NOTICE FOR RESIDENTS OF LOUISIANA, MINNESOTA, MONTANA, NEW MEXICO, TEXAS, UTAH AND WASHINGTON

The Definition of Child In The Definitions Section Of This Certificate Is Modified For The Coverage Listed Below:

For Louisiana Residents (Dental Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 26, regardless of the child's or grandchild's marital status, student status or full-time employment status. Your natural child, adopted child, stepchild or grandchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. In addition, marital status will not prevent or cease the continuation of insurance for a mentally or physically handicapped child or grandchild past the age limit.

For Minnesota Residents (Dental Insurance):

The term also includes Your grandchildren who are financially dependent upon You and reside with You continuously from birth. The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For Montana Residents (Dental Insurance):

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

For Texas Residents (Dental Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

For Utah Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For Washington Residents Dental Insurance:

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to dental treatment are the responsibility of You and the dentist. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Dental Insurance sections of this certificate for more details.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a written response from MetLife to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for your dental insurance.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the dentist. If the dentist agrees to accept part of the payment directly from MetLife, you are responsible for prompt payment of the remaining part of the dentist's charge.
- You should consult with the dentist about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the dentist the most current, complete and accurate information about your medical and dental history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the dentist.

TABLE OF CONTENTS

The bottom left of each page of this certificate has a unique coding which describes the section of the certificate that the page contains (fp = Certificate Face Page, sch = Schedule of Benefits).

Section	Page
CERTIFICATE FACE PAGE.....	1
NOTICES.....	3
TABLE OF CONTENTS.....	35
SCHEDULE OF BENEFITS.....	36
DEFINITIONS	37
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU	40
Eligible Classes	40
Date You Are Eligible For Insurance.....	40
Enrollment Process For Dental Insurance	40
Date Your Insurance Takes Effect.....	40
Date Your Insurance Ends	41
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS	42
Eligible Classes For Dependent Insurance	42
Date You Are Eligible For Dependent Insurance.....	42
Enrollment Process For Dependent Dental Insurance	42
Date Your Insurance Takes Effect For Your Dependents	42
Date Your Insurance For Your Dependents Ends	43
DENTAL INSURANCE: SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE	45
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.....	46
For Mentally or Physically Handicapped Children	46
For Family And Medical Leave	46
COBRA Continuation For Dental Insurance.....	46
At The Employer's Option	46
EVIDENCE OF INSURABILITY	48
DENTAL INSURANCE	49
DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES	52
Type A Covered Services.....	52
Type B Covered Services.....	52
Type C Covered Services	54
DENTAL INSURANCE: EXCLUSIONS.....	56
DENTAL INSURANCE: COORDINATION OF BENEFITS.....	59
FILING A CLAIM	64
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS	65
GENERAL PROVISIONS	67
Assignment.....	67
Dental Insurance: Who We Will Pay.....	67
Entire Contract.....	67
Incontestability: Statements Made By You.....	67
Misstatement of Age	67
Conformity With Law.....	67
Autopsy	67
Overpayments	67

SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible, and
- which You elect, if subject to election; and
- which are in effect.

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

For All Active Full-Time Employees

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	50%	50%
Type C Services	50%	50%
Deductibles for:	In-Network	Out-of-Network
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B & Type C	\$50 for the following Covered Services Combined: Type B & Type C
Yearly Family Deductible	\$150 for the following Covered Services Combined: Type B & Type C	\$150 for the following Covered Services Combined: Type B & Type C
Maximum Benefit:	In-Network	Out-of-Network
Yearly Individual Maximum	\$1,000 for the following Covered Services: Type A, Type B & Type C	\$1,000 for the following Covered Services: Type A, Type B & Type C

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a location to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

Child means the following: (for residents of Louisiana, Minnesota, Montana, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

For Dental Insurance, Your natural child; Your adopted child; Your stepchild (including the child of a Domestic Partner) or a child who resides with and is fully supported by You; and who, in each case, is under age 26.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide Us notice, a Child also includes a child for whom You must provide Dental Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

Contributory Insurance means insurance for which the Employer requires You to pay any part of the premium.

Contributory Insurance includes: Personal and Dependent Dental Insurance.

Covered Percentage means the percentage of the Maximum Allowed Charge that We will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or DENTAL INSURANCE sections of this certificate.

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services.

GCERT2000 as amended by GCR09-07 dp

def

DEFINITIONS

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

Dentures means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dependent(s) means Your Spouse and/or Child.

Domestic Partner means each of two people, one of whom is an employee of the Employer, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other;
 4. sharing a primary residence with the other; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

Full-Time means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours a week. Full-Time does not include temporary or seasonal employees.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with Us to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with Us to accept as payment in full for the dental service.

Noncontributory Insurance means insurance for which the Employer does not require You to pay any part of the premium.

GCERT2000 as amended by GCR09-07 dp
def

DEFINITIONS

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful Spouse. The term also includes Your Domestic Partner.

The term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly** means the 12 month period that begins January 1.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your class as shown in the SCHEDULE OF BENEFITS.

For All Active Full-Time Employees

If You are in an eligible class on January 01, 2019, You will be eligible for insurance on that date.

If You enter an eligible class after January 01, 2019, You will be eligible for insurance on the date You enter that class.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dental Insurance only when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance you are a timely entrant, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work.

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the day after the enrollment period, if You are actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During Any Subsequent Dental Enrollment Period

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (CONTINUED)

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible. If You are not currently enrolled for Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the day after the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. the date You retire in accordance with the Employer's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For All Active Full-Time Employees

If You are in an eligible class on January 01, 2019, You will be eligible for Dependent insurance on that date.

If You enter an eligible class after January 01, 2019, You will be eligible for Dependent insurance on the date You enter that class.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

In order to enroll for Dental Insurance for Your Dependents, You must either (a) already be enrolled for Dental Insurance for You or (b) enroll at the same time for Dental Insurance for You.

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance only when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process for Dependent Dental Insurance within 31 days of becoming eligible for Dependent Insurance you are a timely entrant, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the date You enroll

provided You are Actively at Work on that date. If You are not Actively at Work on that date, it will take effect on the day You return to Active Work.

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for Dependent Insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the day after the enrollment period, if You are actively at Work on that date.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (CONTINUED)

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible. If You are not currently enrolled for Dependent Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dependent Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible or change the amount of Your Dependent Insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the day after the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date Your Dental Insurance ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent;
9. for Utah residents, the last day of the calendar month the person ceases to be a Dependent;

GCERT2000

e/dep

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (CONTINUED)

10. the date You retire in accordance with the Employer's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

The following rules will apply if this Dental Insurance replaces other group dental coverage provided to You by the Employer.

Prior Plan means the group dental coverage provided to You by the Employer on the day before the Replacement Date.

Replacement Date means the effective date of this Dental Insurance under the Group Policy.

Rules if You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;
2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
 - the loss of a tooth; and
 - the accumulation of amounts toward:
 - Annual Deductibles;
 - Annual Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
 - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
 - the date this Dental Insurance ends.

Rules if You and Your Dependents were NOT covered under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;
2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and
3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL INSURANCE

The following applies to employers with 20 or more employees that are not church or government plans:

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Employer for information regarding continuation of insurance under COBRA.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff up to 2 months.
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 9 months.
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence up to 2 months.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (CONTINUED)

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

DENTAL INSURANCE

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the PDP, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from Us to choose a Dentist.

The PDP does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, We will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, We recommend that You:

- identify Yourself as an insured in the Preferred Dentist Program; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the Preferred Dentist Program.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-275-4638 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

In-Network

If a Covered Service is performed by an In-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

Out-of-Network Dentists may charge You more than the Maximum Allowed Charge. If an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible;
- any other part of the Maximum Allowed Charge for which We do not pay benefits; and
- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

DENTAL INSURANCE (CONTINUED)

Maximum Benefit Amounts

The Schedule of Benefits sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

For example, if a Covered Service is received Out-of-Network and We pay \$300 in benefits for such service, \$300 will be applied toward both the In-Network and the Out-of-Network Maximum Benefit Amounts applicable to such service.

Deductibles

The Deductible amounts are shown in the Schedule of Benefits.

The Yearly Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each Year before We will pay benefits for such Covered Services.

We apply amounts used to satisfy Yearly Individual Deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met.

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service. The Deductible Amount will be applied based on when Dental insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is "incurred". When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

Alternate Benefit

If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

DENTAL INSURANCE (CONTINUED)

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than \$300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your Insurance ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your Insurance ends; and
- the device is installed within 31 days after the date the Insurance ends.

We will pay benefits for a 31 day period after Your Insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your Insurance ends; and
- the Cast Restoration is installed within 31 days after the date the Insurance ends.

We will pay benefits for a 31 day period after Your Insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your Insurance ends; and
- the treatment is finished within 31 days after the date the Insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, are limited to once every 6 months.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), are limited to once every 6 months.
4. Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months.
5. Bitewing x-rays but not more than 1 set every calendar year.
6. Full mouth or panoramic x-rays once every 5 calendar years.
7. Dental x-rays except as mentioned elsewhere in this certificate.
8. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) once every 6 months.
9. Topical fluoride treatment for a Child under age 18, but not more than once in a calendar year.
10. Space maintainers for a Child under age 14, once per lifetime per tooth area.

Type B Covered Services

1. Intraoral-periapical x-rays.
2. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.
3. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
4. Diagnostic casts.
5. Sealants or sealant repairs for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 60 months.
6. Preventive resin restorations, which are applied to non-restored first and second permanent molars, but not more than once per tooth every 60 months.
7. Interim caries arresting medicament application applied to permanent bicuspid and 1st and 2nd molar teeth, but not more than once per tooth every 60 months.
8. Protective (sedative) fillings.
9. Initial placement of amalgam fillings.
10. Replacement of an existing amalgam filling, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

11. Initial placement of resin fillings.
12. Replacement of an existing resin filling, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
13. Emergency palliative treatment to relieve tooth pain.
14. Simple extractions.
15. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited two times in any calendar year less the number of teeth cleanings received during such calendar year.
16. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period.
17. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
18. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 36 month period.
19. Simple Repairs of Cast Restorations but not more than once in a 24 month period.
20. Adjustments of Dentures:
 - if at least 6 months have passed since the installation of the existing removable Denture; and
 - not more than once in any 12 month period.
21. Repair of Dentures but not more than once in a 24 month period.
22. Addition of teeth to fixed and permanent Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
23. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
24. Re-cementing of Cast Restorations or Dentures but not more than once in a 24 month period.
25. Repair of implant supported prosthetics but not more than once in a 24 month period.
26. Local chemotherapeutic agents.
27. Injections of therapeutic drugs.
28. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

Type C Covered Services

1. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
2. Other consultations, but not more than once in a 12 month period.
3. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
4. Surgical extractions.
5. Oral surgery except as mentioned elsewhere in this certificate.
6. Pulp capping (excluding final restoration).
7. Pulp therapy.
8. Apexification/recalcification.
9. Therapeutic pulpotomy (excluding final restoration).
10. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24 month period for the same tooth.

Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
11. Tissue Conditioning, but not more than once in a 36 month period.
12. Prefabricated crown, but no more than one replacement for the same tooth surface within 10 calendar years.
13. Initial installation of Cast Restorations (except an implant supported Cast Restoration).
14. Replacement of Cast Restorations (except an implant supported Cast Restoration), but only if at least 10 years have passed since the most recent time that:
 - a Cast Restoration was installed for the same tooth surface; or
 - a Cast Restoration for the same tooth surface was replaced.
15. Core buildup, but no more than once per tooth in a period of 10 calendar years.
16. Labial veneers, but no more than once per tooth in a period of 10 calendar years.
17. Post and cores, but no more than once per tooth in a period of 10 calendar years.
18. Initial installation of fixed and permanent Denture:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
19. Replacement of a non-serviceable fixed and permanent Denture if such Denture was installed more than 10 calendar years prior to replacement.
20. Initial installation of full or removable Dentures:

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

- when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
21. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture.
22. Replacement of a non-serviceable full or removable Denture if such Denture was installed more than 10 calendar years prior to replacement.
23. Relinings and rebasings of existing removable Dentures:
- if at least 6 months have passed since the installation of the existing removable Denture; and
 - not more than once in any 36 month period.
24. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 calendar year period:
- when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
25. Cleaning and inspection of a removable appliance once every 6 months.
26. Repair of implants, but not more than once in a 10 calendar year period.
27. Implant supported prosthetics, but no more than once for the same tooth position in a 10 calendar year period:
- when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
28. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging and TMJ non-invasive physical therapies. However, cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period and TMJ non-invasive physical therapies will not be covered more than once in a 12 month period.

DENTAL INSURANCE: EXCLUSIONS

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (for residents of Texas, see notice page section).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law;
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.

DENTAL INSURANCE: EXCLUSIONS (CONTINUED)

Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.

The term does not include:

- any plan, program or coverage provided by a government as an employer; or
 - Medicare.
20. The following when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
 21. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
 22. Caries susceptibility tests.
 23. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 24. Other fixed Denture prosthetic services not described elsewhere in this certificate.
 25. Precision attachments, except when the precision attachment is related to implant prosthetics.
 26. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 27. Addition of teeth to a partial removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 28. Addition of teeth to a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 29. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
 30. Implants to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 31. Implants supported prosthetics to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
 32. Occlusal adjustments.
 33. Fixed and removable appliances for correction of harmful habits.
 34. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
 35. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota.

DENTAL INSURANCE: EXCLUSIONS (CONTINUED)

36. Orthodontic services or appliances.
37. Repair or replacement of an orthodontic device.
38. Duplicate prosthetic devices or appliances.
39. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
40. Intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, We may reduce what We pay based on what the other Plans pay. This Coordination of Benefits section explains how and when We do this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a Covered Person must pay it, and
- it is at least partly covered by one or more of the Plans that provide benefits to the Covered Person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred) such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, We treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
 - second surgical opinions;
 - pre-certification of services;
 - use of providers in a Plan's network of providers; or
 - any other similar provisions.

We won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

Job-Related Injury or Sickness means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan which limit benefits based on benefits or services provided under;

- Government Plans; or
- Plans which the employer , Policyholder (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the employer (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the “Rules to Decide Which Plan Is Primary” section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, We determine which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan’s rules.

The first rule below which will allow Us to determine which Plan is Primary is the rule that We will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee),

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if as a result the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then We will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We need certain information to apply the Coordination of Benefits rules. We have the right to decide which facts We need. We may get facts from or give them to any other organization or person. We do not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give us any facts We need to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case We may pay the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount We pay is more than We should have paid under this Coordination of Benefits provision, We may recover the excess from one or more of:

- the person We have paid or for whom We have paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

FILING A CLAIM

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-275-4638. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1

A claimant can request a claim form by calling Us at 1-800-275-4638.

Step 2

We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3

When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

Step 4

The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim for Dental Insurance benefits may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 15 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify You within 15 working days after We have received the Proofs of loss, state the reason why the extension is needed, and state when it will make its determination. If the claim still remains incomplete, MetLife will, 30 days from the initial notification and every 45 days thereafter, send to You a letter explaining the reasons additional time is needed and state when MetLife will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.

Upon receipt of a Covered Service, You may assign Dental Insurance benefits to the Dentist providing such service.

Dental Insurance: Who We Will Pay

If You assign payment of Dental Insurance benefits to Your or Your Dependent's Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay Dental Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Employer. The entire contract with the Employer is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Employer's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if We determine that:

- the total amount paid by Us on a claim for Dental Insurance is more than the total of the benefits due to You under this certificate; or

GENERAL PROVISIONS (CONTINUED)

- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

We may recover such overpayment in accordance with that agreement.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

"THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION"

PLAN PRIVACY INFORMATION

Notwithstanding any other Plan provision in this or other sections of the Plan, the Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined therein. The Plan Administrator and/or his or her designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

The term "Plan Sponsor" means Insight PA Cyber Charter School.

The term "Plan Administrator" means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to be the Plan Administrator.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.
- Other uses relating to plan administration, which are approved in writing by the Plan Administrator or Plan Privacy Officer.
- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

(A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

Chief Financial Officer, Human Resources Manager

(B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

(C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.

Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section.

IV. Participants Rights

Participants and their covered dependents will have the rights set forth in the Plan's or its dental insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its dental insurer.

V. Privacy Complaints/Issues

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator shall be final and be given full deference by all parties.

VI. Security

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.



Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- process claims and other transactions
- perform business research
- confirm or correct your information
- market new products to you
- help us run our business
- comply with applicable laws

Sharing Your Information With Others

We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)

- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. Select “Privacy Policy” at the bottom of the home page. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions/More Information

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
MetLife Insurance Company USA
SafeGuard Health Plans, Inc.

MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Dental Insurance:

If you take a leave from employment for “service in the uniformed services,” as that term is defined in USERRA, and as a consequence your dental insurance coverage under your employer’s group dental insurance policy ends, you may elect to continue dental insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for dental insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total dental insurance premium, including any amount that your employer was paying before the leave began.

You and your covered dependents insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) while you have dental insurance coverage under your employer’s group dental insurance policy pursuant to USERRA. Contact your employer for more information.

INSIGHT PA CYBER CHARTER SCHOOL

EFFECTIVE JANUARY 1, 2019

Group Plan Booklet Certificate

ALL MEMBERS

Vision Care Expense Insurance

In any discrepancy between this on-line Group Plan Booklet Certificate and the master contract, the master contract will govern. This on-line Group Plan Booklet Certificate does not guarantee benefits or eligibility. All terms, provisions, conditions, limitations, and exclusions shown in the Group Plan Booklet Certificate and master policy (including any supplements) will apply. Copies of the Group Plan Booklet Certificate may be obtained from the Plan Administrator.

Member's Signature

This insurance has been designed to provide financial help for a Member when a covered loss occurs. The insurance is established through a Group Policy issued by the Company, Nippon Life Insurance Company of America.

Member rights and benefits are determined by the provisions of the Group Policy. This booklet-certificate briefly describes those rights and benefits. It outlines what the Member must do to be insured. It explains how to file claims. It is the Member's booklet-certificate while they are insured.

THIS BOOKLET-CERTIFICATE REPLACES ANY PRIOR BOOKLET-CERTIFICATE THE MEMBER MAY HAVE RECEIVED. If the Member has any questions about this new booklet-certificate, please contact the Policyholder. In the event of future changes to the Member's insurance, he or she will be provided with a new booklet-certificate or a booklet-certificate rider.

If the Member has an electronic booklet-certificate, paper copies of this booklet-certificate are also available. Please contact the Policyholder to request a paper copy.

PLEASE READ THIS BOOKLET-CERTIFICATE CAREFULLY. The Company suggests starting with a review of the terms listed in the DEFINITIONS section on page NBV 136-1 (J) of this booklet-certificate. The meanings of these terms will help the Member understand the insurance.

The group insurance policy and the Member's insurance under the Group Policy may be discontinued or altered by the Policyholder or the Company at any time without the Member's consent.

These booklet-certificate forms are subject to change upon final review by the state agency that approves insurance booklets.

The insurance provided in this booklet-certificate is subject to the laws of the state of Pennsylvania.

NIPPON LIFE INSURANCE COMPANY OF AMERICA
P.O. Box 25951, Shawnee Mission, KS 66225-5951

BENEFIT ADVICE

THE COMPANY WANTS TO HELP THE INSURED PERSON BE A WISE VISION CARE CONSUMER. PLEASE CALL WITH ANY QUESTIONS ABOUT THIS VISION CARE INSURANCE.

English and Non-English Toll-Free Telephone Number: 1-800-374-1835 during normal business hours.

Japanese Toll-Free Telephone Number: 1-800-971-0638 during normal business hours.

Korean Toll-Free Telephone Number: 1-877-827-8713 during normal business hours.

REFER TO THE CLAIM PROCEDURES SECTION (PAGE NBV 146-1 (J)) OF THIS BOOKLET-CERTIFICATE FOR MORE DETAILED INFORMATION.

BOOKLET-CERTIFICATE TABLE OF CONTENTS

	PAGE
SUMMARY OF BENEFITS.....	NBV 102-1 (J) (PPO)
HOW TO BE INSURED	
Members.....	NBV 115-1 (J)
Dependents.....	NBV 125-1 (J)
CONTINUATION OF INSURANCE.....	NBV 117 A-1 (J)
COBRA CONTINUATION.....	NBV 117 B-1 (J)
FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA).....	NBV 117 C-1 (J)
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA).....	NBV 117 D-1 (J)
DESCRIPTION OF BENEFITS	
Vision Care Expense Insurance (Payment Provisions).....	NBV 600-1 (J)
Vision Care Expense Insurance.....	NBV 622-1 (J)
COORDINATION WITH OTHER BENEFITS	
Vision Care Expense Insurance.....	NBV 156-1 (J)
CLAIM PROCEDURES.....	NBV 146-1 (J)
STATEMENT OF RIGHTS.....	NBV 150-1 (J)
Supplemental Information.....	NBV 150-1 (J)
DEFINITIONS.....	NBV 136-1 (J)

**SUMMARY OF BENEFITS
(Effective January 1, 2019)**

VISION CARE EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give the Insured Person quick access to the information he or she will most often want to review. **Please read the other sections of this booklet-certificate for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

Scheduled Benefits are based on the Member's Class and the status of his or her Dependents:

Class	Scheduled Benefit
All Members and their Dependents.....	As shown below

PREFERRED PROVIDER ORGANIZATION (PPO)

The Policyholder participates in a Preferred Provider Organization (PPO) network established and administered by the PPO shown on the Insured Person's identification card.

Preferred Provider Organization networks are arrangements whereby Physicians and other providers are contracted to furnish, at negotiated costs, vision care for Members of participating Policyholders.

It is expected that the Policyholder's participation in the PPO will result in significant savings of funds needed to maintain the Member's insurance. These savings are to be passed on to the Member in the form of higher benefits payable for Covered Charges received by Insured Persons from Preferred Providers.

Please note that the Policyholder's participation in the PPO network does not mean that the Insured Person's choice of provider will be restricted. The Insured Person may still seek needed vision care from any Ophthalmologist, Optometrist or Optician he or she wishes. However, in order to avoid higher charges and reduced benefit payments, the Insured Person is urged to obtain such care from Preferred Providers whenever possible.

A current listing of the participating providers is available through an on-line Preferred Provider directory. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review Preferred Provider directories for the PPO Network. If the Insured Person does not have internet access, the Insured Person can call the number on the Insured Person's ID card. The Company recommends that the Insured Person (1) verify his or her provider's participation in the network before seeking treatment; and (2) confirm the provider's PPO participation when making an appointment.

VISION CARE EXPENSE INSURANCE

BENEFITS PAYABLE

Benefits will be payable for Treatment or Service received on a Rolling Benefit Plan basis as shown below.

Visual Service or Vision Materials Per Insured Person		
Benefit Frequency		
Complete Visual Analysis/Vision Exam	Once per 12 consecutive months	
Standard Plastic Lenses or Contact Lenses	Once per 12 consecutive months	
Frames	Once per 24 consecutive months	
Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
Complete Visual Analysis/Vision Exam with Dilation if necessary	\$10 Copay	\$30
Retinal Imaging	up to \$39 discount	No Benefits Payable
Contact Lens Fitting (Contact Lens Fitting and 2 follow-up visits are available once a Complete Visual Analysis/Vision Exam has been completed.)		
- Standard	\$0 Copay	\$40
- Premium	\$0 Copay, 10% discount off retail price, then apply \$40 Allowance	\$40
Frames (Any available frame at provider location)	\$130 Allowance, then 20% discount off balance over \$130	\$65
Standard Plastic Lenses		
- Single Vision Lens	\$10 Copay	\$15
- Bifocal Lens	\$10 Copay	\$23
- Trifocal Lens	\$10 Copay	\$40
- Lenticular Lens	\$10 Copay	\$40
- Standard Progressive Lens	\$75 Copay	\$23
- Premium Progressive Lens		

Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
Tier 1	\$95 Copay	\$23
Tier 2	\$105 Copay	\$23
Tier 3	\$120 Copay	\$23
Tier 4	\$75 Copay, then 80% of charge less \$120 Allowance	\$23
Lens Options		
- UV Coating	\$15	No Benefits Payable
- Tint (Solid and Gradient)	\$15	No Benefits Payable
- Standard Plastic Scratch Coating	\$0	\$5
- Standard Polycarbonate – Insured Persons age 19 and older	\$40	No Benefits Payable
- Standard Polycarbonate - Dependent Children under age 19	\$0	\$20
- Anti-Reflective Coating - Standard	\$45	No Benefits Payable
- Polarized	20% discount off retail price	No Benefits Payable
- Photochromic/Transitions Lens	\$75	No Benefits Payable
- Anti-Reflective Coating - Premium		
Tier 1	\$57	No Benefits Payable
Tier 2	\$68	No Benefits Payable
Tier 3	80% of charge	No Benefits Payable
- Other Add-Ons	20% discount off retail price	No Benefits Payable
Contact Lenses (in lieu of the Standard Plastic Lens benefit) This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.		

Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
- Conventional	\$0 Copay, \$130 Allowance, then 15% discount off balance over \$130	\$104
- Disposable	\$0 Copay, \$130 Allowance, then balance over \$130	\$104
- Medically Necessary	\$0 Copay	\$210
** Laser Vision Correction		
- Lasik or PRK from U.S. Laser Network	15% discount off retail price or 5% discount off promotional price	No Benefits Payable
Additional Pairs Benefit	40% discount off the purchase of an additional pair of Standard Plastic Lens and frames and a 15% discount off the purchase of an additional pair of conventional Contact Lenses each 12 consecutive months, once the benefit above has been utilized.	No Benefits Payable

*Reimbursement for a Non-PPO Provider will be the lesser of the amount shown above or the actual cost from Non-PPO Provider.

Discounts are not applicable to Visual Services or Vision Materials provided by Non-Preferred Providers. Discounts described above are not insured benefits. Discounts do not apply to benefits provided by other group benefit plans. Discounts may not be combined with any other discounts or promotional offers, and the discount does not apply to Preferred Provider professional services, disposable Contact Lenses or certain brand name Vision Materials in which the manufacturer imposes a no-discount practice or policy.

**For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

The Contact Lenses benefit will be in lieu of the Standard Plastic Lens and frame benefit. If Contact Lenses are chosen, there will be no benefits payable for the Standard Plastic Lens benefit for a period of 12 consecutive months from the date of service and there will be no benefits payable for the frame benefit for a period of 24 consecutive months from the date of service.

Lens Options or Add-Ons listed above as a Covered Visual Service or Vision Material are paid for in addition to the Standard Plastic Lenses, as indicated above. Lens Options or Add-Ons that are not a Covered Visual Service or Vision Material, or that exceed the stated maximums, are the Insured Person's responsibility to pay to the provider.

Allowance

The Allowances for an Insured Person during any period of 12 consecutive months (24 months for frames) will not exceed the Allowances shown in this section. Benefit Allowances provide no remaining balance for future use within the same benefit frequency.

See page NBV 622-1 (J) for a complete description of Vision Care Expense Insurance.

HOW TO BE INSURED – MEMBERS

VISION CARE EXPENSE INSURANCE

Eligibility

Persons enrolling for insurance must be a Member who Resides in the United States.

If the person is a Member on January 1, 2019, the person will be eligible on the later of that date or the first of the Insurance Month coinciding with or next following the date the person completes the Eligibility Waiting Period.

If the person is not a Member until later, the person will be eligible on the first of the Insurance Month coinciding with or next following the date the person completes the Eligibility Waiting Period.

The Eligibility Waiting Period is a period of 30 days during which the person is continuously Actively at Work.

If a person elects to waive insurance under the Group Policy because such person is covered under group vision care expense coverage or coverages provided by a Dependent's employer, the date such coverage terminates because that Dependent is no longer eligible under his or her employer's coverage will be considered the date the person is eligible to request insurance as described in this section. Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Dates - Actively at Work

If the Member is not Actively at Work on the date the Member's insurance would otherwise be effective, the Member's insurance will not be in force until the day the Member returns to Active Work.

This Actively at Work requirement will be waived for the Member if:

- the Member is absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- the Member was Actively at Work on the last scheduled work day before the date of the absence; and
- the Member was capable of Active Work on the day before the scheduled effective date of the insurance or change in the insurance, whichever is applicable.

Individual Incontestability and Eligibility

All statements made by any person insured will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the Insured Person's insurance unless:

- the insurance has been in force for less than three years during the Insured Person's lifetime; and
- the statement is in Written form Signed by the Insured Person; and
- a copy of the form which contains the statement is given to the Insured Person or the Insured Person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, the Company may, at any time, adjust premiums and benefits to reflect the correct age.

Effective Date for Initial Insurance

The Member must request initial insurance on a form provided by the Company.

If the Member is required to contribute towards the cost of his or her insurance, insurance will normally be in force on:

- the date the Member is eligible, if he or she makes the request within 31 days after the date such person is eligible; or
- the first of the Insurance Month coinciding with or next following the date of the Member's request, if he or she makes the request within 31 days after the date such person is eligible.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described below.

If request for contributory insurance is made more than 31 days after the date a Member is eligible and other than during an Annual Open Enrollment Period or a Special Enrollment Period described below, insurance for such Member will become effective as described below for Late Enrollees.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during an Annual Open Enrollment Period described below, insurance for such Member will become effective as described below under Annual Open Enrollment Period.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under Special Enrollment Period.

If the Member is not required to contribute toward the cost of his or her insurance, insurance will normally be in force on the date the Member is eligible.

However, if the Member is not Actively at Work on the date insurance would otherwise be effective, his or her insurance will not be in force until the date he or she returns to Active Work.

Effective Date for Late Enrollees

If a Late Enrollee requests insurance other than during an Annual Open Enrollment Period or a Special Enrollment Period, the effective date of insurance for the Late Enrollee will be the day immediately following completion of the Annual Open Enrollment Period, provided on such date:

- the Member continues to meet the Group Policy's definition of a Member; and
- for Dependent insurance, the Dependent continues to meet the Group Policy's definition of Dependent.

Annual Open Enrollment Period

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
- during any previous Annual Open Enrollment Period; or
- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

- must meet the eligibility requirements described in the Group Policy; and
- may not be covered under an alternate vision care expense coverage offered by the Policyholder, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period is the one-month period immediately prior to the Policy Anniversary date. The Policy Anniversary date is January 1.

The effective date for any qualified individual requesting insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): A Special Enrollment Period provision described below will not apply to the Member or his or her Dependent Child if:

- the Member is enrolled (or eligible to be enrolled but had failed to enroll during a previous enrollment period); and
- the Member failed to enroll his or her Dependent Child during a previous enrollment period; and
- the Member is required by a QMCSO or NMSN as defined by federal law and state insurance laws to provide vision care coverage for his or her Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to the Member and/or his or her Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for the Member's or his or her Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Special Enrollment Period

A Special Enrollment Period will be available for a Member or Dependent if enrollment is made after the first period in which the Member or Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage. A Special Enrollment Period will apply to the Member or Dependent if all of the following conditions are met:
 - the Member was covered under another group vision care expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
 - the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under COBRA or a state continuation provision, due to exhaustion of the continuation); and
 - request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

“Loss of eligibility” does not include:

- a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the vision care expense coverage); or
 - a loss due to a spouse’s voluntary termination of his or her vision care expense coverage; or
 - a loss due to a spouse’s voluntary termination of his or her Dependent vision care expense coverage.
- Newly Acquired Dependents. A Special Enrollment Period will apply to the Member or Dependent if:
 - the Member is enrolled (or is eligible to be enrolled but failed to enroll during a previous enrollment period); and
 - a person becomes the Member’s Dependent through marriage, birth, adoption or Placement for Adoption; and
 - request for enrollment is made within 31 days after the later of the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Vision Care Expense Insurance is available to the Member under the Group Policy.

The effective date of the Member’s or Dependent’s insurance will be:

- in the event of marriage the date of such marriage; or
- in the event of a Dependent Child’s birth, the date of such birth; or

- in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of change in status.

A change in the Member's Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change.

However, if the Member is not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day he or she returns to Active Work.

Termination

Unless continued as provided below or on page NBV 117 A-1 (J), NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J), a Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or
- the end of the Insurance Month in which the Member ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases Active Work.

Termination for Fraud

The Company may, at any time, terminate an Insured Person's eligibility under the Group Policy:

- in Writing and with 31 day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, upon finding in a civil or criminal case that an Insured Person has submitted claims that contain false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, when an Insured Person has submitted a claim which, in good faith judgment and investigation, an Insured Person knew or should have known, contains false or fraudulent elements under state or federal law.

Termination of Preferred Provider Organization (PPO)

The Company has the right to terminate the Preferred Provider Organization (PPO) portion of the Group Policy if the Company or the Preferred Provider Organization (PPO) terminates the arrangement.

The Company also has the right to identify different Preferred Provider Organizations from time to time and to terminate the designation of any Preferred Provider at any time.

Termination of Insurance While Outside of the United States

If the Member is outside the United States, his or her insurance will automatically terminate. However, the Member will continue to be eligible for benefits provided under the Group Policy if the Member is temporarily outside of the United States for a period of six months or less for one of the following reasons:

- travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided the Insured Person is either:
 - enrolled and attending an accredited school in a foreign country; or
 - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U. S. grants academic credit.

Continuation

If the Member ceases Active Work because he or she is sick or injured, he or she may be eligible for limited continuation of insurance for not more than six consecutive months.

If the Member ceases Active Work because of layoff or approved leave of absence, insurance may be continued on a limited basis for up to one month.

If insurance under the Group Policy is subject to COBRA or USERRA, this continuation period will run concurrent with the COBRA or USERRA period.

The Member's insurance may also be continued by paying the required contribution, if any, under the continuation provisions described on page NBV 117 A-1 (J), NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J).

All continuation provisions may run concurrently.

If the Member is interested in continuing his or her insurance beyond the date it would normally terminate, he or she should consult with the Policyholder before his or her insurance terminates.

Contact the Policyholder with reinstatement questions.

HOW TO BE INSURED - DEPENDENTS

VISION CARE EXPENSE INSURANCE

Eligibility

A Member's spouse must Reside in the United States to be eligible for Dependent insurance.

A Member will be eligible for Dependent insurance on the latest of:

- the date the Member is eligible for Member insurance; or
- the date the Member enters a class for which Dependent insurance is provided; or
- the date the Member first acquires a Dependent.

If the Member's Dependent is employed and is covered under group coverage provided by his or her employer, the date such coverage is terminated because the Member's Dependent is no longer eligible under his or her employer's plan will be considered the date the Member first acquired that Dependent (and any other Dependent who was also covered under such coverage). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for his or her Dependents will be in force under the same terms as described earlier for Member insurance, except:

- a Dependent acquired after the Member's Dependent insurance is already in force will be insured on the date acquired.
- the Actively at Work requirement does not apply to the Member's Dependents.

Individual Incontestability and Eligibility

Dependents will be subject to the Individual Incontestability and Eligibility provision as described earlier for Member insurance.

Annual Open Enrollment Period

Dependents will be subject to the Annual Open Enrollment Period provisions as described earlier for Member insurance.

Special Enrollment Period

Dependents will be subject to the Special Enrollment Period provisions as described earlier for Member insurance.

Termination

Unless continued as provided on page NBV 117 A-1 (J), NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J):

- Insurance for all of the Member's Dependents will terminate on the earliest of:
 - the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or
 - the date Dependent insurance is removed from the Group Policy; or
 - the date the Member's insurance ceases; or
 - the end of the Insurance Month in which the last premium is paid for the Member's Dependent Vision Care Expense Insurance; or

- Insurance for a spouse or Dependent Child, will terminate on the earlier of:
 - for contributory insurance, the end of any Insurance Month, if requested by the Member before that date; or
 - the last day of the Insurance Month in which a spouse or Dependent Child ceases to be a Dependent as defined in NBV 136-1 (J). However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in page NBV 136-1 (J).

Notwithstanding the above, insurance will terminate on the last day of the calendar month in which the Member's Dependent Child turns age 26.

However, Vision Care Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap. The Member must apply for this continuation within 31 days after the child reaches the maximum age.

Termination for Fraud

Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Insurance While Outside of the United States

Dependents will be subject to the Insurance While Outside of the United States provisions as described earlier for Member insurance.

Continuation

Under certain conditions, Dependent Vision Care Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on page NBV 117 A-1 (J), NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J).

CONTINUATION OF INSURANCE

CONTINUATION OF COVERAGE – STATE REQUIRED - PENNSYLVANIA

- **Member Vision Expense Insurance - Continuation for Active Duty Reservists (Applicable only to plans that are not subject to COBRA)**

If active employment ceases because the Member is a member of a reserve component of the Armed Forces of the United States, including the National Guard, who voluntarily or involuntarily enters active duty (other than for training), the Policyholder will, at no cost to the Member, continue vision insurance for at least the first 30 days of the military duty.

After expiration of the first 30 days, the Member may continue coverage under the Group Policy during the period of active duty as described below.

The Member's coverage and coverage for the Member's eligible Dependents may be continued, subject to payment of contributions at the same rate paid by the Policyholder, if, on the date the Member is ordered to active duty:

- the Group Policy is in force; and
- the Member is not eligible for coverage under any other group vision expense plan except TRICARE; and
- the Member requests continuation, in writing, within 30 days of being ordered to active duty.

If the Member qualifies, coverage as set forth above may be continued until the earliest of:

- the date the Group Policy is terminated; or
- the date the Member is eligible for other group vision expense insurance, except TRICARE; or
- the end of any Insurance Month, desired, if requested by the Member on or before that date; or
- the date the last premium is paid for the Member's coverage; or
- the date the Member terminates active duty or is discharged after a period of hospitalization incident to such active duty lasting less than one year.

If the Member resumes active employment for the Policyholder upon return to civilian status, coverage for the Member and eligible Dependents will be effective on the date the Member is again actively employed.

If the Member does not resume active employment for the Policyholder upon return to civilian status, coverage will terminate at the end of the Insurance Month in which the Member ceases to be a Member.

If the Member does not elect to continue this coverage during a period of active duty, the Member's coverage and eligible Dependents coverage will be suspended during the period of active duty, beginning on the 31st day of military duty.

If the Member elected suspension and then resumes active employment for the Policyholder upon return to civilian status and the Group Policy is still in force, the Member's coverage and eligible Dependents coverage will be reactivated as of the date of termination of the period of active duty. No waiting period will be applied to the Member or eligible Dependents except:

- completion of a waiting period not satisfied prior to the date of suspension; and
- a condition manifested during the Member's period of active duty which has been determined to have been incurred in the line of duty by the Secretary of Veterans Affairs.

If the Member elected suspension and does not resume active employment for the Policyholder upon return to civilian status and the Group Policy is still in force, the Member's coverage and eligible Dependents coverage will be terminated as of the date of termination of the period of active duty.

These continuation and suspension provisions for active reservists will not apply if insurance is subject to ERISA or if continuation insurance is available under COBRA or USERRA.

- **Dependent Vision Expense Insurance - Continuation for Full-Time Students Who Are Active Duty Reservists (Applicable only to plans that are not subject to COBRA)**

With respect to Full-Time Students who are active duty reservists, the eligibility for coverage under the Member's policy will be extended for a period of time equal to the duration of the Full-Time Student's service on active duty or until the Full-Time Student is no longer a Full-Time Student. The eligibility of the Full-Time Student for coverage under the Member's policy will not terminate because of the age of the Full-Time Student when the Full-Time Student's educational program was interrupted because of military duty.

In order to qualify for this extension, the Member must:

- submit a form approved by the Department of Military and Veterans Affairs notifying the Company that the Full-Time Student has been placed on active duty;
- submit a form approved by the Department of Military and Veterans Affairs notifying the Company that the Full-Time Student is no longer on active duty; and

- submit a form approved by the Department of Military and Veterans Affairs showing that the student has reenrolled as a Full-Time Student for the first term or semester starting 60 or more days after his or her release from active duty.

All of the other provisions and limitations of the Group Policy will apply during this continuation period.

The provisions of this subsection will not apply if the Group Policy has been terminated.

These continuation and suspension provisions for active reservists will not apply if coverage is subject to ERISA or if continuation coverage is available under COBRA or USERRA.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group vision coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of the insurance.

A. Qualified Persons/Qualifying Events

Continuation of group vision coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

- (1) A Member (and any covered Dependents) following the Member's:
 - (a) termination of employment for a reason other than gross misconduct; or
 - (b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, absence due to sickness or injury, or, when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

- (2) A Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
- (3) A Member's surviving spouse (and any Dependent Children) following the Member's death; and
- (4) A Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
- (5) A Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

- (6) A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
- (7) If the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree vision benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, vision coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

- (1) 36 months dating back to the Member's entitlement to Medicare; or
- (2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A(2) through A(5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

- (1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
- (2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends on the earliest of the following:

- (1) The date the maximum continuation period ends; or
- (2) The date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A(7); or
- (3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
- (4) The date the Group Policy is terminated (and not replaced by another group vision plan); or

- (5) The date the qualified person becomes covered by another group vision plan; however, this does not apply to a person who is already covered by the other group vision plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group vision plan are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A(7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group vision coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider vision enrollment options carefully.

M. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Vision Plan: INSIGHT PA CYBER CHARTER SCHOOL Vision Plan
Contact Name/Area: INSIGHT PA CYBER CHARTER SCHOOL Benefits Department
Address: 350 EAGLEVIEW BLVD,
SUITE 350
EXTON, PA 19341
Phone Number: (484) 713-4353

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

FMLA and Other Continuation Provisions

If the Policyholder is an Eligible Employer and if the continuation portion of the FMLA applies to the Eligible Employee's insurance, these FMLA continuation provisions:

- Are in addition to any other continuation provisions of the Group Policy, if any; and
- Will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed forces members, reserve members, National Guard members, and members in contingency operations, as defined under federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a "covered service member" with a "serious injury or illness".

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

Contact the Policyholder for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if insurance would otherwise end because the Member enters into active military duty or inactive military duty for training, he or she may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because the Member enters active military duty or inactive military duty for training, insurance may be continued until the earliest of:

- for the Member and Dependents:
 - the date the Group Policy is terminated; or
 - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
 - the date 24 months after the date the Member enters active military duty; or
 - the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.

- for the Member's Dependents:
 - the date Dependent Vision Care Expense Insurance would otherwise cease as provided on page NBV 125-1 (J); or
 - the end of any Insurance Month, if requested by the Member before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If the Member qualifies for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE (PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by the Group Policy for an insured class, the Member and his or her Dependents must:

- be insured in that class on the date vision Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES section as described on page NBV 146-1 (J).

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS as described on page NBV 156-1 (J).

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE

If the Member or Dependent undergoes a Complete Visual Analysis/Vision Exam or purchases any of the listed Vision Materials, the Company will pay the vision care benefits for Covered Charges as described in the SUMMARY OF BENEFITS section on page NBV 102-1 (J) (PPO).

Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures shown in the SUMMARY OF BENEFITS section. Also:

- Covered Charges will include only those charges for Treatment or Service that begins (see below) while the Member and Dependents are insured under the Group Policy.
- Covered Charges will include only those charges for Treatment or Service that is completed while the Member and Dependents are insured under the Group Policy, except for Vision Materials ordered before insurance ended are delivered, and the Treatment or Service is rendered to the Insured Person within 31 days from the date of such order.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis/Vision Exam or Vision Materials that are not Medically Necessary; or
- Visual Services or Vision Materials that are not specifically listed as a Covered Charge in the Summary of Benefits; or
- a Visual Service performed by other than an Ophthalmologist, Optometrist or Optician; or
- Vision Materials not prescribed by an Ophthalmologist or Optometrist; or
- a Visual Service or Vision Materials provided by any person in the Member's or Dependent's Immediate Family; or
- Plano Lens or non-prescription lenses or non-prescription sunglasses; or
- duplication or replacement of a Vision Material that is broken, lost, or stolen; or
- more than one Complete Visual Analysis/Vision Exam in any period of 12 consecutive months, regardless if Medically Necessary; or
- more than once in any period of 12 consecutive months for Standard Plastic Lenses or Contact Lenses or once in any period of 24 consecutive months for frames, regardless if Medically Necessary; or
- any additional Visual Service outside a basic Vision Exam for Contact Lenses, except for Contact Lens Fitting; or
- hearing exams and hearing aids; or
- laser vision correction; or

- solutions and/or cleaning products for Standard Plastic Lenses or glass lens or Contact Lenses; or
- frame cases; or
- low (subnormal) Vision Materials or aniseikonic lenses; or
- Orthoptics, vision training and any associated supplemental testing; or
- any eye exam or corrective eyewear required by the Policyholder as a condition of employment, including but not limited to industrial or safety glasses; or
- Visual Services or Vision Materials provided by another vision plan or any group medical expense coverage; or
- two pairs of Standard Plastic Lenses or glass lens, in lieu of Bifocal Lens, Trifocal Lens, Premium Progressive Lens or Standard Progressive Lens; or
- cosmetic items; or
- additional cost for Visual Services or Vision Materials over the Allowance; or
- experimental or non-conventional treatment or device; or
- a Visual Service or Vision Materials for which the Member or Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
- a Visual Service or Vision Materials that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- a Visual Service or Vision Materials provided as the result of a sickness or injury that is due to war or act of war; or
- a Visual Service or Vision Materials provided as a result of the participation in criminal activities; or
- a Visual Service or Vision Materials provided as the result of:
 - an injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
 - a sickness covered by a Workers' Compensation Act or other similar law; or
- a Visual Service or Vision Materials provided outside the United States, unless the Insured Person is temporarily outside the United States for a period of six months or less for one of the following reasons:
 - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
 - a business assignment; or

- Full-Time Student status, provided the Insured Person is either:
 - enrolled and attending an accredited school in a foreign country; or
 - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- medical or surgical treatment of the eye, eyes, or supporting structures, unless such treatment is performed during a Complete Visual Analysis/Vision Exam, subject to the applicable Complete Visual Analysis/Vision Exam maximum benefit shown in the SUMMARY OF BENEFITS section.

VISION CARE EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when the Member or Dependent has vision care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Insured Person or the Prevailing Charge for a Treatment or Service.

Definitions

* "Plan" is any of these which provide benefits or services for, or because of, vision care or treatment:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party vision expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts, including the self-insured equivalent of any minimum benefits required by law.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

The term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

- * In the event a husband and wife are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

"This Plan" is the vision care expense benefits described in this booklet-certificate.

"Primary Plan/Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary or a Secondary Plan as to another Plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for vision care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When benefits are reduced under a primary Plan because an Insured Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to preferred provider arrangements.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the part of a calendar year during which the Member or Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The Plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - Secondary to the Plan covering the person as a Dependent; and
 - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- **Dependent Child-Parents Not Separated or Divorced.** If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- **Dependent Child-Separated or Divorced Parents.** If a Dependent Child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent Child are determined in this order:
 - first, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child; and
 - finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the vision care expenses of the Dependent Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the Plans covering the Dependent Child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.
- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- **Continuation of Coverage.** If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:
 - first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
 - second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for vision care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider vision enrollment options carefully.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Company within 20 calendar days after the date of loss. Notice given by or on behalf of the insured or the beneficiary to the insurer or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Except in the case of vision care received from Preferred Providers, claim forms and other information needed to prove loss must be filed with the Company in order to obtain payment of benefits. The Policyholder will provide forms to assist in filing claims. If the forms are not provided within 15 calendar days after the Company receives such notice of claim, the Insured Person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Company within 12 months after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Company receives proof of loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of loss includes the patient's name, the Member's name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Company may request additional information to substantiate the Insured Person's loss or require a Signed unaltered authorization to obtain that information from the provider. The Insured Person's failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. Within 15 working days after receipt by the Company of properly executed proof of loss, the claimant will be advised of the acceptance or denial of the claim. The denial will be given to the claimant in writing and the claim file of the Company will contain a copy of the denial. If a claim cannot be processed due to incomplete information, the Company will either deny the claim or send a Written explanation requesting information prior to the expiration of the 15 working days. If the investigation remains incomplete, the Company will send the claimant a Written explanation of the reason additional time is needed and state when a decision on the claim may be expected, within 30 days from the date of the initial notification and every 45 days thereafter until a decision has been made on the claim. If the Company does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for its denial.

A claimant may request an appeal of a claim denial by Written request to the Company within 180 calendar days of receipt of the notice of denial. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will make a full and fair review of the claim. The Company may require additional information to make the review. The Company will notify the claimant in Writing of the appeal decision within 30 calendar days of receiving the appeal request for post-service claims and 15 calendar days for pre-service claims. The Company will notify the claimant in Writing of the appeal decision within 72 hours for urgent care claims. The appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal review. The appeal must be requested in Writing within 60 calendar days of receipt of the final internal adverse benefit determination. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will make a full and fair review of the claim. The claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. The Company will make a determination within 30 calendar days of request for a voluntary appeal review for post-service claims and 15 calendar days for pre-service claims.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. The Company offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the voluntary appeal review process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means the Member or the Member's Dependent.

Preferred Providers

When a person becomes insured, such person will be issued an identification card. This card should be presented to each Preferred Provider at the time the Insured Person receives needed vision care. Each Preferred Provider will provide the Insured Person with a claim form and other filing assistance.

Facility of Payment

The Company will normally pay all benefits to the Member. However, if the claimed benefits result from a Dependent's vision care, the Company may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Company to the full extent of those payments.

- If payment amounts remain due upon the Member's death, those amounts may, at the Company's option, be paid to the Member's estate, spouse, child, parent, or provider of vision care services.
- If the Company believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Company may pay whoever has assumed the care and support of the person.
- Benefits payable to a Preferred Provider will be paid directly to the Preferred Provider on behalf of the Insured Person.

Medical Examinations

The Company may have the person whose loss is the basis for claim examined by a Physician. The Company will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 60 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in this booklet-certificate.

As a participant in this plan the Member is 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 the 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 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Member, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Member and his or her Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing 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 the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Member and other plan participants and beneficiaries. No one, including the Member's employer, union, or any other person, may fire the Member or otherwise discriminate against the Member in any way to prevent the Member from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcing the Member's Rights

If the Member's claim for a welfare benefit is denied or ignored, in whole or in part, the Member has 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 the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to \$110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Questions

If the Member has any questions about his or her plan, he or she should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if he or she needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

**SUPPLEMENT
TO THE BOOKLET-CERTIFICATE**

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. Employer Plan Identification Number:

EIN: 46-1166314
PN: 501

2. Type of Administration:

Vision Care Expense Insurance: Insurance Contract

3. Plan Administrator:

INSIGHT PA CYBER CHARTER SCHOOL
350 EAGLEVIEW BLVD,
SUITE 350
EXTON, PA 19341

See the employer for the business telephone number of the Plan Administrator.

4. Plan Sponsor:

INSIGHT PA CYBER CHARTER SCHOOL
350 EAGLEVIEW BLVD,
SUITE 350
EXTON, PA 19341

A complete list of the employers and/or employee organizations sponsoring the plan may be obtained upon Written request to the plan administrator and is also available for examination at the business office of the plan administrator.

Upon Written request, participants may receive from the ERISA Plan Administrator information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan, and if the employer or employee organization is a plan sponsor, their address.

5. **Agent for Service of Legal Process:**

INSIGHT PA CYBER CHARTER SCHOOL
350 EAGLEVIEW BLVD,
SUITE 350
EXTON, PA 19341
Telephone: (484) 713-4353

Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

All active Full-Time Employees of INSIGHT PA CYBER CHARTER SCHOOL, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet-certificate (page NBV 136-1 (J)).

7. **Sources and Methods of Contributions to the Plan:**

Employee pays none of employee's contribution. Employee pays all of Dependent's contribution (if employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

December 31.

DEFINITIONS

Several words and phrases used to describe insurance are capitalized whenever they are used in this booklet-certificate. These words and phrases have special meanings as explained in this section.

Allowance means the benefit available to an Insured Person for Covered Charges provided by PPO Providers.

Anti-Reflective Coating means a lens coating that allows more light to pass through the lens, cutting down on glare and distracting reflections. This coating is good for night driving and is cosmetically appealing because it allows others to see a person's eyes rather than the light reflection off the lenses.

Active Work; Actively at Work mean the active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Bifocal Lens means lenses prescribed to correct for both far away and up close.

Company means Nippon Life Insurance Company of America.

Complete Visual Analysis/Vision Exam includes:

- case history and professional consultation; and
- examination for disease or abnormalities; and
- determination of the ranges of clear single vision; and
- measurement of refraction, eye muscle coordination, and balance; and
- special working distance analysis.

Contact Lens Fitting (premium) means more complex applications, including but not limited to, multifocal, postsurgical, and gas-permeable of soft, spherical wear Contact Lenses for single vision prescriptions.

Contact Lens Fitting (standard) means routine applications of clear, soft, spherical, daily-wear Contact Lenses for single vision prescriptions.

Contact Lenses (conventional) means contact lenses designed for long-term use (up to one year) and can be either daily or extended wear. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Contact Lenses (disposable) means contact lenses designed to be thrown away daily, weekly, bi-weekly, monthly, or quarterly. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Contact Lenses (Medically Necessary) means contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured Person from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

- Aphakia (after cataract surgery). A pair of prescription Single Vision Lens or multifocal eyeglass lenses and frames can be provided in addition to Contact Lenses for this condition.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement other than Keratoconus when vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

Reimbursement of Medically Necessary Contact Lenses will be considered as payment in-full if utilizing the services of a Preferred Provider. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Copay means a specified dollar amount that must be paid by an Insured Person each time certain or specified services are rendered.

Covered Charges means the Vision Exam or Visual Service(s) or Vision Material(s) that qualify for benefits under the Group Policy. Covered Charges are shown in the Summary of Benefits.

Dependent means:

- A Member's spouse, if that spouse:
 - Resides in the United States; and
 - is not in the armed forces of any country; and
 - is not insured under the Group Policy as a Member; and
 - is legally wed to the Member.
- A Member's Dependent Child (or Children), as defined below.

Dependent Child; Dependent Children means:

- A Member's natural, stepchild or legally adopted child, if that child is less than 26 years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- A Member's foster child, provided:
 - the child meets the requirements above; and
 - the child has been placed with the Member or the Member's spouse insured under this booklet-certificate by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; and
 - the required documentation has been provided and the child is approved in Writing by the Company as a Dependent Child.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, as determined by the Company, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Dilation means the process of administering special pharmaceutical eye drops into the eyes in order to enlarge the pupils. Dilating the pupil allows in more light and facilitates the view of the internal structures of the eye including the lens, optic nerve, blood vessels, and retina in greater detail. Dilation is a key component of an exam as it sometimes leads to the detection and diagnosis of certain eye diseases, possibly at their earliest stages, which include diabetes, high blood pressure, macular degeneration, retinal detachment, and glaucoma.

Eligibility Waiting Period means with respect to a group vision plan and an individual who is a potential enrollee in the plan, the period of time that must pass before insurance for an individual who is otherwise eligible to enroll for benefits under the terms of the plan can become effective.

Full-Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means a Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on the Member for principal support.

Generally Accepted means Treatment or Service which:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed vision and scientific literature; and
- is in general use in the relevant vision community; and
- is not under continued scientific testing or research.

Group Policy means the policy and booklet-certificate of group insurance issued to the Policyholder by the Company which describes benefits and provisions for the Policyholder and Insured Persons.

Immediate Family means an Insured Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month means calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for insurance; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and
- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

LASIK or PRK means a type of refractive eye surgery for correcting myopia (nearsightedness), hyperopia (farsightedness), and astigmatism. LASIK is performed by an Ophthalmologist using a laser to remove the inner layers of corneal tissue. PRK (photorefractive keratectomy) is a kind of laser eye surgery used to remove the outer layer of the cornea and flatten the cornea.

Late Enrollee means a Member or Dependent who enrolls more than 31 days after the date the Member or Dependent is eligible other than during a Special Enrollment Period. The term also means a Member or Dependent who:

- was previously insured under the Group Policy but elected to terminate the insurance; and
- reapplies for insurance more than 31 days after the termination date; and
- does not qualify for one of the Special Enrollment Periods.

Lens Options or Add-Ons means any lens option or add-on that does not come with the basic lens.

Lenticular Lens means an antiquated technology used in situations requiring such high plus power that a full field meniscus lens would be impractical (because of thickness, weight, and fit). This area of power is usually located in the center of the lens and takes on the appearance of a "bubble".

Medically Necessary means as determined by the Company, any Visual Services or Vision Materials that are prescribed by an Ophthalmologist, Optometrist or Optician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

Member means any person who Resides in the United States and is a Full-Time Employee of the Policyholder.

Non-Preferred Provider(s)/Non-PPO Provider(s) means an Ophthalmologist, Optometrist, or Optician not contracted with the Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

Ophthalmologist means a person who is licensed by the state in which he or she practices as a Doctor of Medicine (M.D.) or Osteopathy (D.O.) and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder.

Optician means a person or business that grinds and/or dispenses eyeglass lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder.

Photochromic/Transitions Lens means lenses that change color based on different levels of light.

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by the Company, which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires to be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: optometrist and physician's assistant.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plano Lens means a lens that has no refractive power.

Polarized means a lens add-on that cuts down on glare from the sun.

Policy Anniversary means January 1, and the same day of each following year.

Policyholder means the business, firm, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider(s)/PPO Provider(s) means an Ophthalmologist, Optometrist, or Optician contracted with a Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

The Policyholder's participation in a PPO network does not mean that an Insured Person's choice of provider will be restricted. The Insured Person may seek needed vision care from any Ophthalmologist, Optometrist or Optician of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the Insured Persons are urged to obtain such care from Preferred Providers whenever possible.

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Premium Progressive Lens means multifocal lenses that produce a gradual change in focus without lines or junctions and are the latest technology. These designs are the lens manufacturer's highest technology models and produce the optimal ease of adaptation, comfort, and widest zones for reading and intermediate vision. The determination of a Premium Progressive Lens designation takes into consideration the date the design was introduced to the market, the technology/design features, advantages and benefits and the wholesale list price from the manufacturer's laboratory.

Reside(s) in the United States means a Member and Dependent who:

- maintain a home in the United States; and
- live in that home in the United States; and
- do not leave the United States for more than six consecutive months.

Retinal Imaging means a diagnostic tool that provides high-resolution, permanent digital records of the inner eye.

Rolling Benefit Plan means benefits begin anew from the date of service as described in the SUMMARY OF BENEFITS section on page NBV 102-1 (J) (PPO).

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Single Vision Lens means lenses prescribed to correct for one field of vision: either far away or up-close.

Standard Plastic Scratch Coating means a film or coating that can be applied to optical surfaces. The coating does not interfere with how the lens functions and does not affect vision, but creates a permanent bond with the lens that reduces the appearance of hairline scratches which is common to standard plastic lenses. Though an anti-scratch coating is not 100% scratch-proof, it helps to prevent minor scratches that can easily happen to a regular lens. These minor scratches can damage the surface of the lens and impair vision. An anti-scratch coating acts as a protective layer making the lenses more durable and safe.

Standard Polycarbonate means lenses that are more durable than regular plastic lenses, and are very lightweight. They also have greater impact resistance than any other lens material, making them the lenses of choice for sports eyewear, children, or those with active lifestyles.

Standard Progressive Lens means multifocal lenses that produce a gradual change in focus without lines or junctions but may not be each manufacturer's most current models. The determination of a Standard Progressive Lens designation takes into consideration the date the design was introduced to the market, the technology/design features, advantages and benefits and the wholesale list price from the manufacturer's laboratory.

Treatment or Service, when used in this booklet-certificate, will be considered to mean: "treatment, service, substance, material or device".

Tint (Solid and Gradient) means a lens add-on that reduces the light that enters the eyes. This can be physician recommended or for fashion purposes.

Trifocal Lens means lenses prescribed to correct for three fields of vision: far away, up-close, and intermediate.

United States (U.S.) means the contiguous United States consisting of the 48 adjoining U.S. states plus Washington, D.C. (federal district), Alaska, and Hawaii, on the continent of North America.

UV Coating means an eyeglass lens coating that protects eyes from harmful ultraviolet light found in sunlight.

Vision Material(s) means corrective eyeglass lenses, frames, and Contact Lenses.

Visual Service(s) means any services or treatment by an Ophthalmologist, Optometrist or Optician, including but not limited to a Complete Visual Analysis/Vision Exam.

We, Us, and Our mean Nippon Life Insurance Company of America, West Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

Notice of Privacy Practices for Protected Health Information (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how your medical information obtained in connection with your health benefit plan administration may be used and disclosed and how you can access the information. The terms of this Notice apply to current and former plan members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and has been revised most recently effective November 1, 2013.

We are required by law to maintain the privacy of our current and former members' and dependents' protected health information, to provide notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of any revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization

Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed an authorization form. You have the right to revoke an authorization by written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to revoke an authorization can be obtained from the Privacy Officer and will be honored upon receipt by us.

Disclosures for Treatment

We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment

We may use and disclose your protected health information as necessary for payment purposes. For instance, we may use it to process or pay claims, to exercise legal subrogation rights, to perform a Precertification, to determine whether services are for medically necessary care, or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Uses and Disclosures for HealthCare Operations

We may use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, premium rating (when allowable by law), conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your protected health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures

We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment

We may request and receive from you and your health care providers protected health information prior to your enrollment under the group policy. When allowable by law, we may use this information to determine rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state privacy laws.

Genetic Information

We will not use or disclose any genetic information we obtain about you in any regard, including underwriting purposes.

Business Associate

Certain aspects and components of our insurance services are performed by outside vendors known as 'Business Associates.' Business Associates are under an independent duty to safeguard your privacy. Additionally we require them to sign a Business Associate Agreement, which is a contract to adhere to our privacy practices.

Plan Sponsor

We may disclose your protected health information to the plan sponsor, provided that the plan sponsor certifies that the information will be used and maintained in a compliant confidential manner and will not be utilized or disclosed for employment-related actions or decisions or in connection with any other benefit plan of the plan sponsor.

Family, Friends and Personal Representatives

With your approval, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your health care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures

We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Uses and Disclosures Requiring Authorization

We are required by law to obtain your authorization prior to using or disclosing your protected health information in the following circumstances:

- Uses and disclosures of protected health information for marketing purposes.
- Uses and disclosures that constitute the sale of protected health information.
- Most uses and disclosures of psychotherapy notes.
- Other uses and disclosures not described in this notice will be made only with the individual's written authorization. An individual may revoke an authorization, provided that the revocation is in writing and we have not taken action in reliance upon the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Protected Health Information

You have the right to request restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951.

A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information

You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information

You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with some exceptions. To request access to your information, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee may be charged for copying and postage.

Amendment of Your Protected Health Information

You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information

You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee may be charged for any subsequent request for an accounting during that same time period.

Complaints

If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374-1835; Japanese (800) 971-0638; or Korean (877) 827-8713.



Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, Kansas 66225-5951

LI8000

EXECUTION VERSION

ATTACHMENT: 2.2-5

**LEASE AGREEMENT
BETWEEN
SBH ASSOCIATES, L.P.
AND
INSIGHT PA CYBER CHARTER SCHOOL**

LEASE AGREEMENT

THIS LEASE AGREEMENT ("Lease") made as of the 29 day of August, 2017, by and between SBH ASSOCIATES, L.P., a Pennsylvania limited partnership with its principal place of business at 120 Pennsylvania Avenue, Malvern, Pennsylvania 19355 ("**Landlord**"), party of the first part, and INSIGHT PA CYBER CHARTER SCHOOL, a Pennsylvania corporation, with its principal place of business at 350 Eagleview Boulevard, Suite 350, Exton, Pennsylvania 19341 ("**Tenant**"), party of the second part.

WITNESSETH THAT, for and in consideration of the rents, covenants and agreements herein contained and intending to be legally bound hereby, the parties hereto covenant and agree as follows:

1. REFERENCE DATA:

As used in this Lease, the following terms shall be defined as indicated and refer to the data set forth in this Section 1.

TENANT'S ADDRESS:

350 Eagleview Boulevard
3rd Floor, Suite 350
Exton, PA 19341
Attention: Office Manager

With a copy to:

Duane Morris LLP
30 South 17th Street
Philadelphia, PA 19103-4196
Attn: Alan Kessler, Esquire

And

K12 Virtual Schools LLC
2300 Corporate Park Drive
Herndon, VA 20171
Attn: General Counsel

PREMISES:

ALL THAT approximately 14,862 rentable square foot portion in Suite 350 of the three-story office building (the "**Building**"), along with related parking and common areas, known as 350

Eagleview Boulevard, Exton, PA ("**Property**") and further identified on the floor plans attached as Exhibit "A" attached with and made a part herein.

TERM; RENEWAL OPTION:

The initial term of this Lease shall be five (5) years. The term of the Lease shall commence on the Commencement Date and shall expire on the last day of the month in which the fifth (5th) anniversary thereof occurs (the "**Initial Term**"), unless the Commencement Date is the first day of a calendar month, in which event the Initial Term shall end on the day immediately preceding the fifth (5th) anniversary of the Commencement Date.

Provided that there exists no Event of Default (hereinafter defined) on the part of Tenant under the Lease at the time of the exercise of the Option to Extend (hereinafter defined), or at the commencement of the Extension Period (hereinafter defined), Tenant shall have the option to extend (sometimes the "Option to Extend") the Term for one (1) extension period of five (5) years (such extension period is hereinafter referred to as the "Extension Period") on the same terms and conditions as specified in the Lease, except that the Base Rent during the Extension Period shall be determined based upon the then "Fair Market Rental Rate" for five (5) year leases for comparable space, and calculated on a per square foot basis. As used herein, the term "Fair Market Rental Rate" shall mean the per square foot base rental rate, including annual escalations, then being charged by landlords for comparable space in comparable office buildings in the trade area of the Building for leases commencing on or about the commencement of the Extension Period, taking into consideration the use, location and floor level of the applicable building, leasehold improvements provided, the term of the lease under consideration, the extent of services provided thereunder and other adjustments to the base rent and any other relevant term or condition in making such evaluation, assuming, however, for purposes of the foregoing analysis, that the Premises is fit for immediate use and occupancy in its "AS IS" condition and that no work is required to be done by Landlord with respect thereto. If Tenant fails to give Landlord written notice of Tenant's election to exercise the Option to Extend at least nine (9) months prior to the expiration of the Term (but no sooner than twelve (12) months prior to the expiration of the Term), the Option to Extend shall automatically terminate and be of no further force or effect, it being understood that time is of the essence with respect to the exercise of the Option to Extend.

COMMENCEMENT DATE:

The date that Landlord substantially completes Landlord's Work (hereinafter defined) to the Premises, as more specifically set forth in Exhibit "B" attached hereto and incorporated herein and in Section 3 below, and delivers the Premises to Tenant.

BASE RENT:

Base Rent in the following amounts for the following periods shall be due on the first day of each calendar month of the Term:

<u>Lease Year</u>	<u>Base Rent</u>	<u>Monthly Installment</u>	<u>Base Rent / Rentable Square Foot</u>
1	\$308,386.50	\$25,698.88	\$20.75
2	\$315,817.50	\$26,318.13	\$21.25
3	\$323,248.50	\$26,937.38	\$21.75
4	\$330,679.50	\$27,556.63	\$22.25
5	\$338,110.50	\$28,175.88	\$22.75

*The first "Lease Year" shall commence on the Commencement Date and shall end on the last day of the month in which the first anniversary of the Commencement Date occurs, unless the Commencement Date is the first day of a calendar month, in which event the first Lease Year shall expire on the day immediately preceding the first anniversary of the Commencement Date. Each succeeding Lease Year shall be the consecutive twelve (12) month period commencing on the day immediately following the expiration of the previous Lease Year.

OPERATING EXPENSE CHARGES: Tenant's Proportionate Share of the sum of (a) Operating Expenses in the applicable Operating Year in excess of the Operating Expenses in the Base Year and (b) Snow Costs in the applicable Operating Year in excess of the Snow Stop.

BASE YEAR:

Calendar year 2017

SNOW STOP: The average costs and expenses incurred by Landlord for Snow Costs during calendar years 2014 through 2017.

FIXED RENT:

Base Rent plus Operating Expense Charges.

ADDITIONAL RENT:

Sums not including Base Rent which Tenant is obligated to pay to Landlord from time to time pursuant to the terms of this Lease.

TENANT'S PROPORTIONATE SHARE:

Initially 12.18% (14,862/122,000) (Determined by dividing the area of the Premises by the area of the Building.)

PERMITTED USES:

Tenant shall use and occupy the Premises for general office use, virtual instruction, and training and for no other purpose. Notwithstanding anything herein to the contrary, while Landlord acknowledges that Tenant is a charter school, Tenant has represented that it is an on-line school only, and, therefore, in no event may Tenant hold any classes or meetings at the Premises that will be attended by multiple students; provided, however, nothing shall prevent teachers from instructing classes virtually from the Premises or Tenant from providing training sessions to teachers within the Premises. Individual instruction is permitted, but the intent of this Section is to prohibit a multiple number of students from visiting the Premises at any one time, which may, among other things, cause the parking and other common areas to be overburdened. Landlord acknowledges that Tenant from time to time would like to use a portion of the parking lot for events subject to at least thirty (30) days prior written request and the consent of Landlord, which consent shall not be unreasonably withheld, conditioned or delayed. In no event may Tenant use the parking lot more than six (6) times in any calendar year or for more than two (2) days at a time.

TENANT ALLOWANCE:

Provided (i) the Commencement Date shall have occurred and Tenant shall have paid to Landlord the initial installment of Base Rent payable hereunder, (ii) Tenant has delivered to Landlord all paid invoices covering Tenant's costs for Tenant's furniture, fixtures and equipment to be installed in the Premises for Tenant's use therein (collectively, "FF&E"), subject to the provisions of Section 13 hereinbelow set forth, or other tenant improvements, and (iii) Tenant is not in default of any of Tenant's obligations under this Lease, and no event shall have occurred which, with the giving of notice and/or the passage of time will become a default hereunder if uncured by Tenant, then within thirty (30) business days after the satisfaction of each of the foregoing conditions, Landlord shall pay to Tenant up to One Hundred Thousand Dollars (\$100,00.00) in the form of a check as Landlord's contribution to the cost of Tenant's FF&E or other tenant improvements during the first Lease Year only (the "**Allowance**"). The Allowance shall not be applied to the costs of any FF&E or other tenant improvements installed in the Premises after the first Lease Year. If Tenant fails to request the Allowance prior to the end of the first Lease Year, then any undrawn Allowance shall be forfeited and Tenant shall have no further right to draw the same. Tenant shall have the option to submit all requests for Allowance payments at once or as Tenant pays each FF&E or other tenant improvements invoice, provided, however, that to the extent Tenant elects to request incremental Allowance payments as its invoices are paid, each request must be for no less than Twenty Thousand Dollars (\$20,000.00), shall not be submitted more than one time per month and Tenant shall have satisfied all of the conditions set forth in subparagraphs (i), (ii) and (iii) of this Paragraph.

EARLY TERMINATION:

Provided Tenant is not in default under this Lease beyond any applicable notice and cure period, Tenant shall have the right to terminate this Lease if Tenant's charter contract is terminated, revoked or not renewed so that Tenant is prohibited from operating a charter school from the Premises (the "**Termination Option**"). Such Termination Option shall be

effective as of the last day of the thirty-sixth (36th) full month after the Commencement Date (the "**First Termination Right**"), or if Tenant has not exercised the First Termination Right, effective as of the last day of the seventy-second (72nd) full month after the Commencement Date (assuming Tenant has exercised the Option to Extend) (the "**Second Termination Right**"), or if Tenant has not exercised the First Termination Right or Second Termination Right, effective as of the last day of the one hundred eighth (108th) full month after the Commencement Date (the "**Third Termination Right**") (each a "**Early Termination Date**"), provided, that (i) Tenant notifies Landlord in writing (the "**Termination Notice**") of the exercise of the Termination Option not less than ninety (90) days prior to applicable the Early Termination Date and (ii) Tenant pays Landlord a Termination Payment, as hereinafter defined, in immediately available funds, simultaneously with Tenant's delivery of the Termination Notice. The Termination Payment shall be an amount equal to: (A) the unamortized costs incurred by Landlord for (i) Landlord's Work, (ii) the Allowance referenced above, and (iii) all leasing commissions paid by Landlord in connection with this Lease (the "**Recovered Costs**"), which Recovered Costs shall be amortized over a term of thirty-six (36) months, with interest at the annual rate of eight percent (8%) for the First Termination Right; and (B) for the Second Termination Right and Third Termination Right, the unamortized costs incurred by Landlord for the commissions paid by Landlord for the Option to Extend period amortized over a term from the beginning of the Option to Extend period through the Early Termination Date, with interest at the annual rate of eight percent (8%) (each the "**Termination Payment**"). Tenant acknowledges and agrees that the Termination Payment is not a penalty and is fair and reasonable compensation to Landlord for the loss of expected rentals from Tenant over the remainder of the scheduled term. If Tenant fails to pay the Termination Payment, Landlord may, at its sole option and in addition to all other rights and remedies, treat Tenant's termination as null and void, or Landlord may elect to accept Tenant's termination and pursue Tenant for damages for failure to pay the Termination Payment. Attached hereto as **Exhibit "F"** is an amortization schedule showing an estimate of the amount of the Termination Payment. Landlord may supplement the same if the Recovered Costs change after completion of Landlord's Work.

2. **DEMISE:**

Landlord hereby demises and lets to Tenant and Tenant hereby hires and leases from Landlord the Premises for the Term, upon the conditions and limitations set forth herein.

3. **CONSTRUCTION BY LANDLORD:**

(A) Landlord shall construct the interior of the Premises ("**Landlord's Work**") in accordance with the floor plans and specifications attached as Exhibit "B" hereto ("**Landlord's Work Plans**"). The Landlord's Work shall be constructed in accordance with all laws applicable to the Landlord's Work using new materials and as would be used in comparable premises in comparable commercial buildings in the area and, upon completion thereof, the Premises will comply with all applicable laws to the extent of the Landlord's Work. The Landlord's Work shall not include wiring for Tenant's phone, computer or data systems. Landlord shall cause all Landlord's Work

to be done in a good and workmanlike manner in conformity with the Landlord's Work Plans. Landlord shall be responsible for all architectural and engineering expenses associated with the Landlord's Work, except with respect to Change Orders initiated by Tenant.

- (B) Landlord shall use its reasonable efforts to cause the Landlord's Work to be carried forward expeditiously and with adequate work forces so as to cause the Premises to be in substantially completed condition on or before the Commencement Date, subject to extension for any time lost by Landlord due to strikes, labor disputes, governmental restrictions or limitations, scarcity of or inability to obtain labor or materials, accidents, fire or other casualties, weather conditions, or any cause similar or dissimilar to the foregoing beyond the reasonable control of Landlord (collectively, "Force Majeure") or Tenant Delay (defined below). Substantial completion shall be deemed to have taken place when Landlord's contractor or a registered architect certifies in writing to Landlord and Tenant that Landlord's Work has been substantially completed.
- (C) Landlord promptly shall correct, at Landlord's cost and expense, all Landlord's Work failing to conform to the Landlord's Work Plans, provided that such defect appears and Tenant gives Landlord written notice thereof during the first 365 days of the Term. Landlord's obligation under this Section 3(C) shall survive Tenant's occupancy of the Premises upon substantial completion. Tenant shall have the right to inspect the progress of the Landlord's Work from time to time upon not less than twenty-four (24) hours prior written notice to Landlord. All such inspections shall be made at Tenant's sole risk and Landlord shall not be liable to Tenant for any damages or losses suffered or incurred by Tenant during such inspection except for damages or losses suffered or incurred due to Landlord's or Landlord's agents' negligence or willful misconduct.
- (D) Changes in the Landlord's Work may be accomplished only by Change Order (defined below) or by Order for Minor Change (defined below). The Term "Change Order" shall mean a written instrument prepared by Landlord and signed by Landlord and Tenant stating their agreement upon (i) a change in the Landlord's Work, (ii) the cost of effecting such change, including the cost associated with any delays in completing the Landlord's Work and (iii) the extent of the adjustment, if any, in the Commencement Date. The term "Order for Minor Change" shall mean a minor change in the scope of the Landlord's Work, not requiring any adjustment in the cost of the Landlord's Work or the Commencement Date.
 - (1) Either Landlord or Tenant may from time to time request changes in the scope of the Landlord's Work, provided that Landlord shall not be obligated to accept any changes requested by Tenant unless a Change Order is issued with respect thereto. Tenant shall pay to Landlord, upon demand, all costs incurred by Landlord, including costs for delays in completing the Landlord's Work, to effect a Change Order requested by Tenant.
 - (2) Landlord may from time to time to issue Orders for Minor Change not inconsistent with the Landlord's Work Plans, which shall be binding on Tenant

unless, within five business days following the date the same is received by Tenant, Tenant notifies Landlord that it disputes the Order for Minor Change. In such event, the Order for Minor Change shall be treated as a Landlord request for a Change Order and shall become effective and binding on Landlord and Tenant only if and after mutual agreement of the parties provided above.

- (E) Immediately upon the completion of Landlord's Work, Tenant and Landlord jointly shall inspect the same in order to determine and record its condition and to prepare a comprehensive list of items that have not been completed (or which have not been correctly or properly completed) in strict conformity with the Landlord's Work Plans (collectively, "Punch List Items"). Landlord thereafter shall proceed promptly to complete and correct all Punch List Items, using commercially reasonable efforts not to disrupt or interfere with Tenant's normal use and enjoyment of the Premises following the Commencement Date. Failure to include an item as a Punch List Item does not alter the responsibility of Landlord to complete all Landlord's Work in strict accordance with the Landlord's Work Plans.
- (F) The term "Tenant Delay" shall mean delay in Landlord's construction of the Landlord's Work to the extent attributable to (i) Tenant's making changes to the Landlord's Work Plans after such documents have been finally approved by Landlord, (ii) Tenant's failure to promptly provide any information requested by Landlord or (iii) interference by Tenant or Tenant's contractors in Landlord's orderly scheduling, sequencing and performance of the Landlord's Work. The Commencement Date shall, at the option of Landlord, be accelerated by the number of days the Landlord's Work is delayed by Tenant Delay.
- (G) Except as expressly set forth herein, Landlord shall have no obligation to perform any work or other improvements as a condition to Tenant's obligations hereunder, and Landlord makes no representations or warranties concerning the Landlord's Work or the Premises, including, but not limited to, any warranties of habitability, merchantability, and/or fitness for a particular use, other than that the Landlord's Work and the Premises comply with the terms of this Lease.

4. TERM:

Subject to the terms of this Lease, the Term shall commence on the Commencement Date and shall expire on (i) the date immediately preceding the fifth (5th) anniversary of the Commencement Date, if the Commencement Date is the first day of a calendar month, or (ii) the last day of the calendar month in which the fifth (5th) anniversary of the Commencement Date occurs, if the Commencement Date is a day other than the first day of a calendar month.

5. BASE RENT:

- (A) Tenant shall pay to Landlord during the Term of the Lease the Base Rent, without notice or demand, in the monthly installments specified in Section 1, in advance on the first day of each calendar month of the Term. The first month's installment of the Base

Rent shall be payable within ten (10) business days of the date of full execution of this Lease and delivery of same to Tenant. If the Term commences other than on the first day of a calendar month, then the installments of Base Rent for the first calendar month of the Term shall be adjusted proportionately, and the aforesaid first installment paid by Tenant upon the execution of this Lease shall be initially applied to the first partial month of the Term, and the balance to the next month.

- (B) Base Rent, Additional Rent and all other sums payable by Tenant to Landlord hereunder shall be paid, without set-off or deduction, in lawful currency of the United States of America to Landlord at the address set forth in the first paragraph of this Lease, or at such other address as Landlord may from time to time designate in writing to Tenant.

Tenant hereby acknowledges that late payment by Tenant to Landlord of rent or other sums due hereunder will cause Landlord to incur costs not contemplated by this Lease, the exact amount of which will be extremely difficult to ascertain. Such costs include, but are not limited to, processing and accounting charges, and late charges which may be imposed upon Landlord by terms of any mortgage or trust deed covering the Premises. Accordingly, if any installment of rent or any sum due from Tenant shall not be received by Landlord or Landlord's designee within five (5) days after said amount is due, then Tenant shall pay to Landlord a late charge of five (5%) percent of such overdue amount, plus any attorney's reasonable fees and court costs incurred by Landlord by reason of Tenant's failure to pay rent and/or other charges when due to Landlord hereunder. The parties hereby agree that such late charges represent a fair and reasonable estimate of the cost that Landlord will incur by reason of the late payment by Tenant. Acceptance of such late charges by Landlord shall in no event constitute a waiver of Tenant's default with respect to such overdue amount, nor prevent Landlord from exercising any of the other rights and remedies granted hereunder. In addition, any amounts due and not paid by Tenant within thirty (30) days after the same is due shall accrue interest at the annual rate of 12% per annum.

6. RENTAL ADJUSTMENTS:

- (A) Subject to Tenant's reimbursement obligations set forth below, Landlord shall pay (i) all operation and maintenance costs and expenses incurred in the operation, repair, replacement and maintenance of the Building, the Property and the common areas thereof, and (ii) all Real Estate Taxes affecting the Property. The term Real Estate Taxes shall mean all real property and personal property taxes, assessments, charges, levies and impositions imposed upon (i) the Property and/or the Building, (ii) the rents derived therefrom, (iii) the fixtures, equipment and all other property of Landlord, real or personal, located in or at the Property and/or the Building and used in the operation of same, and (iv) any license, fee, tax or charge upon Landlord's business of leasing and operating the Property, and all other taxes that may be imposed or levied in lieu of or in substitution for or supplementary to such real property and personal property taxes; provided, however, that the term Real Estate Taxes shall not include any federal or state income tax, or any franchise, capital stock, estate or inheritance taxes of

Landlord ("**Real Estate Taxes**"). Real Estate Taxes shall include Landlord's reasonable costs to appeal Real Estate Taxes or the assessment upon which the same are based.

- (B) Commencing in the year 2018 and during each following calendar year or portion thereof during the Initial Term (an "**Operating Year**"), Tenant shall pay Landlord as additional rent, the Operating Expense Charges. Commencing on January 1, 2018, and on the first day of each month thereafter for the balance of the Term hereof, Tenant shall pay Landlord in advance an amount equal to one-twelfth of the Operating Expense Charges based upon the Operating Expenses and Real Estate Taxes for the previous calendar year. In the alternative, Landlord shall have the right to estimate the Operating Expense Charges payable in any Operating Year, and Tenant shall pay one-twelfth (1/12th) of the amount so estimated during such Operating Year. In such event, on or before the 1st day of May after any Operating Year in which Operating Expense Charges were paid based upon estimates of Landlord, Landlord shall deliver a report to Tenant reflecting the actual Operating Expenses for the previous Operating Year, and the actual amount of Operating Expense Charges payable by Tenant for such year. Concurrently with the payment of the next Operating Expense Charges due (assuming Base Rent is due at least fifteen (15) days after Tenant's receipt of such report), Tenant shall pay to Landlord, or Landlord shall credit Tenant, as the case may be, the difference between (a) the Operating Expense Charges projected by Landlord for the preceding year and paid by Tenant, and (b) the actual Operating Expense Charges due from Tenant for said year.

The Operating Expense Charges due and payable under the terms, covenants, conditions and agreements of this Section, shall be payable to Landlord without any setoff or deduction, and the Base Year costs and the Operating Expense Charge shall be pro-rated during the last calendar year of the term hereof.

- (C) The term "**Operating Expenses**" shall mean all Real Estate Taxes and all costs incurred by or on behalf of Landlord for the repair, replacement, operation, maintenance, securing, insuring and policing of the Building and the Property. Operating Expenses shall not include costs and expenses incurred by Landlord to remove and/or clear snow and ice from the Property ("**Snow Costs**"), but the same shall be included in the Operating Expense Charge as otherwise provided in this Lease. The Operating Expenses shall be determined on an accrual or cash basis method of accounting as determined by Landlord and shall include, without limitation, the following expenses related to such common areas:

- (1) All wages, salaries and fringe benefits of all employees engaged in the management, operation, repair, replacement, maintenance and security of the Building and the Property, including federal, state and local taxes, insurance and all other employee benefits relating thereto;
- (2) All supplies and materials used in the management, operation, repair, replacement, maintenance and security;

- (3) All utilities, including, without limitation, gas, water, sewer, electricity, power, heating, lighting, air-conditioning and ventilating, except that which is submetered to other tenants of the Property;
- (4) All service, maintenance and warranty agreements on the Property and the equipment thereof, including, without limitation, alarm service, heating, air-conditioning, ventilating, cost of chilling and heating water for the HVAC systems for each tenant in the Property and in the common areas, window cleaning and elevator maintenance;
- (5) All casualty and liability insurance (including, without limitation, rental interruption insurance);
- (6) All repairs, replacements and maintenance costs;
- (7) All janitorial, trash removal, pest control and cleaning services;
- (8) All landscaping expenses;
- (9) All capital improvements or capital expenses; provided that the cost of any such capital improvement shall be amortized over the useful life of such improvement or expense at an interest at the rate of one (1%) per cent per annum above the prime rate of interest as posted in the Wall Street Journal as the same may change, from time to time, and only the annual installment of such amortized amount shall be included in Operating Expenses for any year;
- (10) Costs incurred in renting equipment for use in the Building or Property that are not exclusively used for individual tenants;
- (11) Management fees, security services and governmental licenses and permits; provided that management fees shall not exceed four percent (4%) of base rents for the Building;
- (12) All legal fees, accounting fees and other professional fees except for such fees that are exclusively for claims with individual tenants, that are paid for by insurance, or that are caused by the negligence or willful misconduct of Landlord; and
- (13) All other costs and expenses, dissimilar or similar, necessarily and reasonably incurred by the Landlord in the proper operation and maintenance of a first-class office building.

Notwithstanding the foregoing, the following items shall be excluded from Operating Expenses: (i) costs and expenses for capital improvements, except as set forth in (9) above, (ii) expenses incurred in the leasing of or procuring new tenants (i.e., leasing commissions, advertising expenses and the cost of tenant improvements for new tenants), (iii) legal expenses

pertaining to the enforcement of any lease; (iv) repairs, restoration or other work occasioned by fire, wind, the elements or other casualty, to the extent covered by insurance proceeds received by Landlord; (v) income and franchise taxes of Landlord; (vi) interest or principal payments on any mortgage or other indebtedness of Landlord; (vii) operating expenses which are the individual responsibility of Tenant or of other tenants; and (viii) the cost of any service furnished to any tenant of the Property which Landlord does not make available to Tenant and/or to other tenants leasing space in the Building.

In determining Operating Expenses for any year, the following adjustments shall be made:

- (i) if less than one hundred percent (100%) of the Building rentable area shall have been occupied by tenants at any time during such year, Operating Expenses shall be deemed for such year (including the Base Year) to be an amount equal to the like expenses which Landlord reasonably determines would normally be incurred had such occupancy been one hundred percent (100%) throughout such year;
 - (ii) if any tenant of the Building supplies itself with a service at any time during such year that Landlord would ordinarily supply without separately charging therefor, then Operating Expenses shall be deemed to include the cost that Landlord would have incurred had Landlord supplied such service to such tenant;
 - (iii) if, after the first calendar year of the Term, Landlord successfully obtains a reduction in Real Estate Taxes, then the Base Year Operating Expenses shall thereafter be correspondingly reduced (on a dollars per square foot basis) to the extent of the reduction in Real Estate Taxes; and
 - (iv) The Base Year Operating Expenses shall be adjusted to adjust for average and reasonable allowance for on-going repairs and maintenance and to exclude from the Base Year "extraordinary items" of Operating Expenses incurred in such calendar year. For purposes of this subparagraph, extraordinary items shall mean either (X) cost increases or decreases over the prior calendar year of eleven percent (11%) or more with respect to certain on-going line items of the Operating Expenses, or (Y) items which increase Landlord's total Operating Expenses and such items have not been included in the determination of Operating Expenses by the Landlord (or the Landlord's predecessor in interest) for the prior three years of operating the Building.
- (D) Tenant, at its sole cost, upon not less than five (5) days advance written notice to Landlord, but no more than once annually, shall have the right to review or have an independent third party review (which said third party shall not be permitted to work on a contingency basis), the Operating Expenses and Snow Costs used to calculate the Operating Expense Charges, provided that, if Tenant fails to audit and contest Landlord's determination of Operating Expenses and Snow Costs for a particular calendar year within 12 months following the date on which Landlord delivers to Tenant the Operating Expense report for such calendar year, Landlord's determination of Operating Expenses for such and all prior calendar years shall be deemed final and binding upon Landlord and Tenant. Notwithstanding the first

sentence of this subsection, if the audit review shows that Tenant overpaid Operating Expense Charges in excess of 7% of the Operating Expense Charges originally reported for the audit period, Landlord shall pay for the reasonable and documented costs of such review. All overpayments paid by Tenant shall immediately be credited to Tenant by Landlord. Landlord shall reasonably cooperate with any such reviews during normal business hours.

7. (This Section Intentionally Left Blank)

8. LANDLORD'S SERVICES; PAYMENT OF UTILITY CHARGES:

(A) Landlord shall:

(i) Provide water for drinking, lavatory and toilet purposes drawn through fixtures installed by Landlord;

(ii) Furnish electricity, heat, ventilation and air conditioning to the Premises during Landlord's normal Building operating hours, which normal operating hours shall be from 7:00 a.m. until 7:00 p.m., Monday through Friday. If Tenant requests use of such utilities outside of the Business hours listed in the previous sentence, Tenant shall pay to Landlord the standard rates for such use.

(iii) Provide janitorial services in accordance with Landlord's standard janitorial specifications attached hereto as Exhibit "D";

(iv) Provide elevator service to the Premises in the manner currently provided in the Building, if any;

(v) Provide periodic pest control as determined to be necessary by Landlord; and

(vi) Provide access to the Building and Premises on a "24/7" basis through Landlord's existing security program.

It is understood that Landlord does not warrant that any of the services referred to in this Section will be free from interruption from causes beyond the reasonable control of Landlord. Except as provided below, no interruption of service shall ever be deemed an eviction or disturbance of Tenant's use and possession of the Premises or any part thereof or render Landlord liable to Tenant for damages, permit Tenant to abate rent or otherwise relieve Tenant from performance of Tenant's obligations under this Lease.

(B) In addition to the Base Rent and Operating Expense Charges, Tenant shall pay for all utilities (including, without limitation, gas and electricity) that are consumed within the Premises. If a submeter is installed, Tenant shall pay for its consumption of such utility based on its metered usage based upon normal and customary rates of utility providers in the area. If no submeter is installed, Tenant shall pay its share of the charges for such utilities as a part of the Operating Expense Charges; provided that Landlord may elect to calculate

Tenant's charge for any particular utility service based on the percentage which the rentable square footage of the Premises bears to the square footage of the areas of the Building serviced by such utility. Tenant shall pay all utility bills within ten (10) days after receipt by Tenant. Landlord shall at all times have the exclusive right to select the provider or providers of utility service to the Premises and the Property, and Landlord shall have the right of access to the Premises from time to time at reasonable times to install or remove utility facilities by providing at least twenty-four hours' prior written notice to Tenant.

9. **REPAIRS:**

- (A) Except as specifically otherwise provided in this Lease, Tenant, at its sole cost and expense and throughout the Term of this Lease, shall keep and maintain the Premises in good order and condition, free of accumulation of dirt and rubbish, and shall promptly make all non-structural repairs necessary to keep and maintain such good order and condition. Tenant may at its option and sole cost choose to replace lights, ballasts, tubes, ceiling tiles, outlets and similar equipment itself or Tenant may advise Landlord of Tenant's desire to have Landlord make such repairs, at Tenant's expense. If requested by Tenant, Landlord shall make such repairs to the Premises within a reasonable time of notice to Landlord and shall charge Tenant for such services at Landlord's standard rate (such rate to be competitive with the market rate for such services and provided to Tenant prior to performing such repairs). All repairs made by Tenant shall utilize materials and equipment which are at least equal in quality and usefulness to those originally used in constructing the Building and the Premises.
- (B) Except as specifically otherwise provided in this Lease, Landlord shall make or cause to be made all structural repairs to the Building, all repairs which may be needed to the mechanical, HVAC, electrical and plumbing systems in and serving the Premises (excluding repairs to any supplemental HVAC systems, kitchens, any non-Building standard fixtures or other improvements or any other portions of the Premises or fixtures, equipment and improvements therein requiring maintenance of a type or nature not customarily provided by Landlord to office tenants of the Building), and all repairs to exterior windows and glass (including caulking and weatherstripping). Landlord shall have no responsibility to make any repairs unless and until Landlord receives written notice of the need for such repair or Landlord has or should have actual knowledge of the need to make such repair.
- (C) Landlord shall keep and maintain all common areas appurtenant to the Building and any sidewalks, parking areas, curbs and access ways adjoining the Property in a clean and orderly condition, free of accumulation of dirt, rubbish, snow and ice, and shall keep and maintain all landscaped areas in a neat and orderly condition.
- (D) Notwithstanding anything herein to the contrary, repairs to the Premises, Building or Property and its appurtenant common areas made necessary by a negligent or willful act or omission of Tenant or any employee, agent, contractor, or invitee of Tenant shall be made by Landlord at the sole cost and expense of Tenant, payable on demand, except to the extent of insurance proceeds received by Landlord.

10. INSURANCE:

- (A) Tenant, at Tenant's expense, shall maintain in effect throughout the Term, through insurance carriers reasonably satisfactory to Landlord, insurance against claims for personal injury (including death) and property damage, under a policy of commercial general liability insurance, in amounts not less than \$2,000,000 combined single limit in respect of bodily injury (including death) and \$2,000,000 for property damage. Tenant's insurance policy referred to above shall name Landlord, its mortgagees, and its designees an additional insured party(ies).
- (B) Prior to the commencement of the Term, Tenant shall provide Landlord with certificates of the insurance policies herein required to be maintained. All policies shall provide that coverage thereunder may not be reduced or terminated without at least thirty days' prior written notice to Landlord. Tenant shall also furnish to Landlord throughout the Term replacement certificates at least thirty days prior to the expiration date of the then current policies and, upon request of Landlord, shall supply to the requesting party copies of all policies required to be maintained hereunder.
- (C) Each of the parties hereto hereby releases the other from all liability for all injury, loss or damage which may be inflicted upon persons or the property of such party, even if such liability results from the negligence of the other party; PROVIDED, HOWEVER, that this release shall be effective only (i) during such time as the applicable insurance policy carried by such party name the other party as a co-insured or contains a clause to the effect that this release shall not affect said policy or the right of the insured to recover thereunder, and (ii) to the extent of the coverage of such policy. If any policy does not permit such a waiver, and if the party to benefit therefrom requests that such a waiver be obtained, the other party agrees to obtain an endorsement to its insurance policies permitting such waiver of subrogation, if available, and if an additional premium is charged for such waiver, the party benefiting therefrom shall pay same promptly upon being billed therefor.
- (D) Landlord's Building Insurance – As an Operating Expense, Landlord shall keep the Building insured against perils under an insurance policy which is at least as broad as Insurance Service Office (ISO) form CP 1030 in the amount of the full replacement value of the Building.

11. CASUALTY:

- (A) If the Premises are damaged by fire or other casualty, Tenant shall promptly notify Landlord and Landlord shall repair the damaged portions of the Premises, but excluding Tenant's FF&E and other property therein and any improvements or alterations made to the Premises by Tenant after the Commencement Date, provided that if, in Landlord's reasonable judgment, the damage would require more than 60 days of work to repair, or if the insurance proceeds (excluding rent insurance) which Landlord anticipates receiving must be applied to repay any mortgages encumbering

the Building or are otherwise inadequate to pay the cost of such repair, Landlord may terminate this Lease by providing written notice to Tenant within 60 days following the occurrence of the fire or other casualty, which notice shall specify a termination date not less than 30 days after its transmission. If Landlord is so required to repair, the work shall be commenced promptly and completed with due diligence, taking into account the time required for Landlord to procure said insurance proceeds, and construction delays due to shortages of labor or material or other causes beyond Landlord's reasonable control. Tenant shall have the option to terminate this Lease if the repairs to the Premises are not substantially completed within one hundred eighty (180) days of the date Landlord commences such repairs or if the damages occur within the last year of this Lease.

- (B) During the period when Tenant shall be deprived of possession of the Premises by reason of such damage, Tenant's obligation to pay Base Rent under Section 5 and Operating Expense Charges under Section 6 shall abate in the proportion which the damaged area of the Premises bear to the entire Premises.

12. CONDEMNATION:

- (A) If all of the Premises is taken through the exercise of the power of eminent domain, this Lease shall terminate on the date when possession of the Premises is required by the condemning authority. If only part of the Premises is taken, then (i) if the condemnation award is insufficient to restore the remaining portion of the Premises or if such award must be applied to repay any mortgages encumbering the Building, or (ii) if, in addition to a portion of the Premises, a portion of the Building or Property is taken and Landlord deems it commercially unreasonable to continue leasing all or a portion of the remaining space in the Building, or (iii) if a substantial portion of the Premises is so taken, and/or it is commercially unreasonable for Tenant to continue its business within the Premises, then Landlord in the case of (i) and (ii) above and Tenant in the case of (iii) above, shall have the right to terminate this Lease on the date when the condemned portion of the Premises, Building or Property is required to be delivered to the condemning authority, which right shall be exercisable by the exercising party so notifying the other party no later than thirty (30) days prior to such date, if the condemnation notice is received within forty-five (45) days prior to the taking date. Otherwise, such notice shall be provided as soon as reasonably possible.
- (B) If this Lease is not so terminated after a partial condemnation, then after the date when the condemned portion of the Premises is delivered to the condemnor, the Fixed Rent shall be reduced in the proportion which the condemned area bears to the entire area of the Premises, and Tenant's Proportionate Share shall be reduced by the same proportion.
- (C) Tenant shall have the right to claim against the condemnor only for removal and moving expenses and business dislocation damages which may be separately payable to tenants in general under Pennsylvania law, provided such payment does not reduce the award otherwise payable to Landlord. Subject to the foregoing, Tenant hereby

waives all claims against Landlord with respect to a condemnation, and hereby assigns to Landlord all claims against the condemnor including, without limitation, all claims for leasehold damages and diminution in the value of Tenant's leasehold estate.

13. TENANT'S FIXTURES:

Tenant shall have the right to install trade fixtures, office machinery and computer equipment (excluding alterations, improvements and additions which are governed by Section 14) required by Tenant or used by it in its business, provided that same do not impair the structural strength of the Building and further provided that such trade fixtures, office machinery and equipment shall be limited to items normally used in an office building. Without limiting the generality of the foregoing, it is specifically understood and agreed that Tenant shall not have the right to install or operate any electrical equipment or machinery in the Premises (other than normal office machinery and equipment) without Landlord's prior written consent. Tenant shall remove all such trade fixtures, office machinery and computer equipment prior to the end of the Term, and Tenant shall repair and restore any damage to the Premises and Building caused by such installation or removal, provided Tenant shall not be required to repaint or remove any data or other wiring.

14. ALTERATIONS:

Tenant shall not, without on each occasion first obtaining Landlord's prior written consent which consent shall not be unreasonably withheld, conditioned or delayed, make any alterations, improvements or additions to the Premises, except that Tenant may, without the consent of Landlord but with prior written notice to Landlord, make minor improvements to the interior of the Premises ("**Minor Improvements**"), provided that: (i) they do not impair the structural strength, operation or value of the Building, and (ii) Tenant shall take all steps required or permitted by law to avoid the imposition of any mechanics' lien upon the Premises, Building and Property, and upon the completion of any such alterations, improvements, and/or additions, shall deliver to Landlord final releases of liens and claims from any and all contractors, subcontractors, and materialmen performing work or supplying materials in connection with such alterations, improvements, and/or additions. All alterations, improvements and additions shall become part of the Premises and the property of Landlord without payment therefor by Landlord and shall be surrendered to Landlord at the end of the Term; PROVIDED, HOWEVER, if so notified by Landlord, which such notification shall be given by Landlord to Tenant at the time that Landlord gives its consent to such alterations, improvements or additions, as the case may be, Tenant shall, prior to the end of the Term, remove all and any such alterations and improvements made by Tenant after initial occupancy, or the parts thereof specified by Landlord, from the Premises and shall repair all damage caused by installation and removal, provided Tenant shall be required to repaint pursuant to the foregoing obligation. For purposes of this Section 14, "Minor Improvements" shall be defined as those improvements costing no more than \$5,000.

15. MECHANICS' LIENS:

Tenant shall not, in the making of any repairs or alterations to the Premises, suffer or permit any mechanic's, laborer's or materialman's lien to be filed against the Premises, Building, Property or any part thereof by reason of labor or materials supplied or claimed to have been supplied to Tenant; and if any such lien shall be filed, Tenant, within fifteen (15) days after notice of filing, shall cause it to be discharged of record or bonded at Tenant's option.

16. USE OF PREMISES:

Tenant may use and occupy the Premises only for the express and limited purposes listed in Section 1 of this Lease, and the Premises shall not be used or occupied, in whole or in part, for any other purpose without the prior written consent of Landlord. Tenant shall not commit or suffer any waste upon the Premises or Building, or any nuisance or any other act which may disturb the quiet enjoyment of any other tenant in the Building.

17. RULES & REGULATIONS:

Tenant covenants and agrees that Tenant, its employees, agents, invitees, licensees and other visitors, shall observe, and comply materially with, such reasonable Rules and Regulations as Landlord or Landlord's agents may, after notice to Tenant, from time to time adopt with respect to the Building, uniformly applied and enforced among all tenants.

18. GOVERNMENTAL REGULATIONS:

Tenant shall, in the use and occupancy of the Premises, comply materially with all applicable laws, ordinances, notices and regulations of all governmental and municipal authorities, and with the regulations of the insurers of the Premises. Tenant shall keep in force at all times all licenses, consents and permits necessary for the lawful conduct of Tenant's business at the Premises. Nothing in the foregoing shall require the Tenant to perform any work or make any improvements or repairs which the Landlord is required to make pursuant to other provisions of this Lease, unless the same are required by Tenant's particular use of the Premises or any alterations or improvements made by Tenant.

19. SIGNS:

Except for signs which are located wholly within the interior of the Premises and which are not visible from the exterior thereof and except for a sign listing the name of the Tenant on the outside of the entrance door to the Premises, on the monument on the outside of the Building, and in the Building directory, no signs shall be erected by Tenant anywhere upon the Premises, Building or Property. To the extent Landlord approves of any signage, Landlord shall have the right to approve all signs prior to their installation. Design, including size, lettering, colors, and location shall be submitted to Landlord for approval prior to installation. Signs located wholly within the interior of the Premises and not visible from the exterior thereof are excepted from this provision.

20. LANDLORD'S ENTRY:

Landlord and its agents, contractors and invitees shall have the right to enter the Premises at reasonable times with twenty-four hours' notice (except in the case of an emergency) to inspect the same, to exhibit same to prospective purchasers, tenants and mortgagees, and to make any necessary repairs thereto, provided Landlord will only exhibit the Premises to prospective tenants in the last six (6) months of the Term and such entry shall be in a manner to commercially minimize interference with Tenant's use of the Premises. All such entry shall be at the sole risk of the person so entering and Tenant shall not be liable to any person for any damages or losses suffered by such person during or as a result of such entry. Landlord shall not be liable in any manner to Tenant by reason of such entry or the performance of repair work in the Premises and the obligations of Tenant hereunder shall not thereby be affected except for the negligence or willful misconduct of Landlord or Landlord's employees, agents or invitees and except that any repair work shall be performed to the same quality as required of the Landlord's Work; however, Landlord agrees (except in the case of Tenant's default hereunder) that all repair work (excepting only emergency work or work which must, in Landlord's judgment, be performed on an urgent basis) by Landlord shall be performed in a reasonable manner at reasonable times.

21. INDEMNIFICATION:

Except due to the negligence or willful misconduct of Landlord or Landlord's employees, agents or invitees, Tenant shall indemnify, defend and hold Landlord harmless from and against any and all losses, costs, claims, suits, actions and causes of action, whether legal or equitable (including reasonable counsel fees and expenses incurred in defense of any of the foregoing) sustained or arising by reason of Tenant's default in any of its obligations hereunder, any misrepresentation of Tenant, or of the fault or neglect of Tenant or of the failure by Tenant or any of its officers, agents, employees or invitees to fulfill any duty toward the public, or any person or persons whomsoever, which Tenant by reason of its occupancy, use or ownership of the Premises, may owe.

Except due to the negligence or willful misconduct of Tenant's employees, agents or invitees, Landlord shall indemnify, defend and hold Tenant harmless from and against any and all losses, costs, claims, suits, actions and causes of action, whether legal or equitable (including reasonable counsel fees and expenses incurred in defense of any of the foregoing) sustained or arising by reason of Landlord's default in any of its obligations hereunder, any misrepresentation of Landlord, or of the fault or neglect of Landlord or of the failure by Landlord or any of its officers, agents, employees or invitees to fulfill any duty toward the public, or any person or persons whomsoever, which Landlord by reason of its occupancy, use or ownership of the Property, may owe.

22. CURING TENANT'S DEFAULTS:

If Tenant shall default in performing any of its obligations hereunder beyond any applicable cure period, Landlord may (but shall not be so obliged), in addition to Landlord's other rights and remedies and without waiver of such default, cure such default on behalf of Tenant, thereby entering and possessing the Premises if deemed necessary by Landlord. Tenant, upon

demand of Landlord, shall reimburse Landlord for all costs (including reasonable counsel fees) incurred by Landlord with respect to such default, and, if Landlord so elects, Landlord's efforts to cure the same, which costs shall be deemed Additional Rent hereunder.

23. DEFAULT:

(A) If (i) Tenant fails to pay any installment of Base Rent for a period of five (5) days after it is due, (ii) Tenant fails to pay any Additional Rent when due and such failure continues for a period of ten (10) days after written notice from Landlord, (iii) Tenant abandons or vacates the Premises, (iv) Tenant fails to observe or perform any of Tenant's other obligations herein contained and such failure continues for more than thirty (30) days after written notice from Landlord or such longer period as may be necessary so long as Tenant has commenced curing such default and is using diligent efforts to cure the same, (v) Tenant commits an act of bankruptcy or files a petition or commences any proceeding under any bankruptcy or insolvency law, (vi) a petition is filed or any proceeding is commenced against Tenant under any bankruptcy or insolvency law and is not dismissed within sixty (60) days, (vii) Tenant is adjudicated a bankrupt, (viii) a receiver or other official is appointed for Tenant or for a substantial part of Tenant's assets or for Tenant's interests in this Lease and is not removed within sixty (60) days, or (ix) any attachment or execution is filed or levied against a substantial part of Tenant's assets or Tenant's interests in this Lease or any of Tenant's property in the Premises which is not dismissed or satisfied within sixty (60) days, then in any such event, an Event of Default shall be deemed to exist and Tenant shall be in default hereunder, and, at the option of Landlord, in addition to all other legal and equitable remedies: (a) the balance of the Base Rent and all Additional Rent and all other sums to which Landlord is entitled hereunder shall be deemed to be due payable and in arrears, as if payable in advance hereunder; or (b) this Lease and the Term shall, without waiver of Landlord's other rights and remedies, terminate without any right of Tenant to save the forfeiture. Any acceleration of the rent by Landlord shall not constitute a waiver of any right or remedy of Landlord, and if Tenant shall fail to pay the accelerated rent upon Landlord's demand, then Landlord may thereafter terminate this Lease, as aforesaid. Immediately upon such termination by Landlord, Landlord shall have the right to recover possession of the Premises with or without legal process, breaking locks and replacing locks, and removing Tenant's and any third party's property therefrom, and making any disposition thereof as Landlord may deem commercially reasonable.

(B) Following such termination, Landlord shall have the unrestricted right to lease the Premises or any part thereof to any person and pursuant to any terms as Landlord may elect, but Landlord shall have no obligation to rent the Premises so long as Landlord (or any related entity) has other comparable vacant space available for leasing in the general geographical area of the Premises.

(C) LANDLORD SHALL HAVE THE RIGHT TO CONFESS JUDGMENT FOR POSSESSION ONLY IN ACCORDANCE WITH SECTION 36 HEREOF.

(D) Tenant expressly waives: (i) all rights under the Landlord and Tenant Act of 1951, and all supplements and amendments thereto; and (ii) the right to three (3) months' or fifteen (15)

or thirty (30) days' notice required under certain circumstances by the Landlord and Tenant Act of 1951, Tenant hereby agreeing that the respective notice periods provided for in this Lease shall be sufficient in either or any such case.

(E) No act or forbearance by either party shall be deemed a waiver or election of any right or remedy by such party with respect to the other party's obligations hereunder, unless and to the extent that such party shall execute and deliver to the other party a written instrument to such effect, and any such written waiver by such party shall not constitute a waiver or relinquishment for the future of any obligation of the other party. Landlord's acceptance of any payment from Tenant (regardless of any endorsement on any check or any writing accompanying such payment) may be applied by Landlord to Tenant's obligations then due hereunder any priority as Landlord may elect, and such acceptance by Landlord shall not operate as an accord and satisfaction or constitute a waiver of any right or remedy of Landlord with regard to Tenant's obligations hereunder.

(F) If Landlord terminates the Lease or Tenant's right to possession, Landlord shall exercise reasonable efforts to mitigate Landlord's damages. Such efforts need not be greater than the efforts that Landlord generally uses to lease other space in the Building. Landlord will not be deemed to have failed to mitigate if Landlord leases any other premises in the Building before re-letting all or any portion of the Premises. Landlord shall not be deemed to have failed to mitigate if it incurs reasonable re-letting costs. In recognition that the value of the Building depends on the rental rates and provisions of leases of space in it, Landlord's rejection of a prospective replacement tenant on the basis that the prospective rentals are less than Landlord's published rates for new leases of comparable space at the Building at the time in question, or the rent provided in this Lease, or the prospective Lease provisions are less favorable than those contained herein, shall not give rise to any claim that Landlord failed to mitigate Landlord's damages.

24. QUIET ENJOYMENT:

So long as no Event of Default then exists hereunder, Tenant's quiet and peaceful enjoyment of the Premises shall not be disturbed or interfered with by Landlord or by any person claiming by, through or under Landlord.

25. ASSIGNMENT OR SUBLETTING:

Tenant shall not assign, pledge, mortgage or otherwise transfer or encumber this Lease, nor sublet all or any part of the Premises or permit the same to be occupied or used by anyone other than Tenant or its employees without Landlord's prior written approval, which Landlord agrees not unreasonably to withhold, condition or delay; provided, however, that Tenant may assign, without seeking or obtaining such consent, this Lease or any part thereof, to any of its Affiliates if Tenant and Guarantor, if applicable, remain liable hereunder and Tenant provides notice to Landlord prior to the assignment. An "Affiliate" of Tenant is an entity that controls, is controlled by, or under common control with the original Tenant named in this Lease, where "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management policies of an entity. It will not be unreasonable for Landlord to

withhold consent if the reputation, financial responsibility, or business of a proposed assignee or subtenant is unsatisfactory to Landlord, or if Landlord deems such business not to be consonant with that of other tenants in the Building, or if the intended use by the proposed assignee or subtenant conflicts with any commitment made by Landlord to any other tenant in the Building.

Tenant's request for approval shall be in writing and contain the name, address, and description of the business of the proposed assignee or subtenant, its most recent financial statement (unless such assignee or subtenant is a public company) and other evidence of financial responsibility, its intended use of the Premises, and the terms and conditions of the proposed assignment or subletting.

Within thirty (30) days from receipt of such request Landlord shall either: (a) grant or refuse consent; or (b) elect to require Tenant (i) to execute an assignment of lease or sublease of Tenant's interest hereunder to Landlord or its designee upon the same terms and conditions as are contained herein, together with an assignment of Tenant's interest as sublessor in any such proposed sublease, or (ii) if the request is for consent to a proposed assignment of this Lease, to terminate this Lease and the term hereof effective as of the last day of the third month following the month in which the request was received.

Each assignee or sublessee of Tenant's interest hereunder shall assume and be deemed to have assumed this Lease and shall be and remain liable jointly and severally with Tenant for all payments and for the due performance of all terms, covenants, conditions and provisions herein contained on Tenant's part to be observed and performed. No assignment shall be binding upon Landlord unless the assignee shall deliver to Landlord an instrument in recordable form containing a covenant of assumption by the assignee, but the failure or refusal of an assignee to execute the same shall not release assignee from its liability as set forth herein.

Tenant shall pay to Landlord, as Additional Rent hereunder, fifty percent (50%) of all subrents or other sums or economic consideration received by Tenant (after deducting Tenant's reasonable costs of re-letting), whether denominated as rentals or otherwise, in excess of the monthly sums which Tenant is required to pay under this Lease.

Any consent by Landlord hereunder shall not constitute a waiver of strict future compliance by Tenant of the provisions of this Section 25 or a release of Tenant from the full performance by Tenant of any of the terms, covenants, provisions, or conditions in this Lease contained.

Notwithstanding this Section 25 to the contrary, Landlord's consent shall not be required and this Section 25 shall not be applicable in the event that Tenant assigns this Lease to Guarantor, as that term is hereinafter defined, during such period that Guarantor is guaranteeing this Lease, so long as Tenant remains liable hereunder and provides notice to Landlord that Tenant is Guaranteeing this Lease prior to the assignment. In such a case, Guarantor shall have all rights of Tenant after the occurrence of the assignment.

26. SUBORDINATION:

This Lease is and shall be subject and subordinate at all times to any lease under which Landlord is in control of the Premises, to the rights of the owners of the Building and Property, and to all mortgages and other encumbrances now or hereafter placed upon the Premises or the Building and Property, and all advances, amendments and replacements thereof, without the necessity of any further instrument or act on the part of Tenant to effectuate such subordination. Tenant shall from time to time execute and deliver within fifteen (15) days following the request of Landlord or Landlord's mortgagee, grantee or lessor, recordable instruments evidencing such subordination and Tenant's agreement to attorn to the holder of such prior right, provided that such party shall issue to Tenant a non-disturbance agreement in such form provided and approved by Landlord's lender. Notwithstanding the foregoing, any mortgagee may at any time subordinate its mortgage to this Lease, without Tenant's consent, by notice in writing to Tenant, whereupon this Lease shall be deemed prior to such mortgage without regard to their respective dates. If any mortgage is foreclosed and Tenant is provided notice, then Tenant will attorn to and recognize the mortgagee or purchaser at foreclosure sale as Tenant's landlord for the Term and Tenant shall not be liable to Landlord for any further obligations without having to investigate whether such notice is correct.

27. TENANT'S CERTIFICATE:

At any time and from time to time, within ten (10) business days after Landlord shall request the same, Tenant, without charge or expense to Landlord, will execute, acknowledge and deliver to Landlord and to such mortgagee or other party as may be designated by Landlord, a certificate in such form as is attached hereto as Exhibit "C", as may be revised to make it accurate. In the event that Tenant fails to provide such certificate within ten (10) business days after request by Landlord therefor, a default shall exist immediately without the need for Landlord to provide any further notice or opportunity to cure.

28. ACCEPTANCE; SURRENDER:

By entry and possession of the Premises, Tenant thereby acknowledges that Tenant has examined the Premises and accepts the same as being in the condition called for by this Lease subject to the Punch List Items. Tenant, shall, at the end of the Term, promptly surrender the Premises in good order and condition and in conformity with the applicable provisions of this Lease, excepting only reasonable wear and tear and damage by fire or other insured casualty.

29. HOLDING OVER:

This Lease shall expire absolutely and without notice on the last day of the Term, provided that if Tenant, with the prior written consent of Landlord, retains possession of the Premises or any part thereof after the termination of this Lease by expiration of the Term or otherwise, a month-to-month tenancy shall be deemed to exist, and Tenant shall continue to pay the Base Rent and Additional Rent due hereunder. If such holding over exists without Landlord's prior written consent, Tenant shall pay Landlord, as partial compensation for such unlawful retention, an amount calculated on a per diem basis for each day of such continued unlawful retention, equal to 150% of the Base Rent and Additional Rent for the time Tenant thus remains in possession.

Such payments for unlawful retention shall not limit any rights or remedies of Landlord resulting by reason of the wrongful holding over by Tenant or create any right in Tenant to continue in possession of the Premises.

30. NOTICES:

All notices, requests and consents herein required or permitted from either party or the other shall be in writing and shall be deemed given on receipt by either party via the United States Postal Service, registered or certified mail, return receipt requested, postage prepaid, addressed to Landlord at its address aforesaid, with a copy to any mortgagee designated by Landlord, or, as the case may be, addressed to Tenant at its address aforesaid, or to such other address as the party to receive same may designate by notice to the other.

31. BROKER:

Each of the parties represents and warrants that there are no claims for brokerage commissions or finder's fees in connection with the execution of this Lease except for Jones Lang LaSalle, and each party agrees to indemnify the other against, and hold it harmless from, all liability arising from any claims from any other broker including, without limitation, the cost of counsel fees in connection therewith.

32. DEFINITION OF PARTIES:

The word "Landlord" is used herein to include the Landlord named above and any subsequent person who succeeds to the rights of Landlord herein, each of whom shall have the same rights and remedies as it would have had it originally signed this Lease as Landlord, but neither Landlord nor any such person shall have any liability hereunder after it ceases to hold a fee or leasehold interest in the Premises, except for obligations which may have theretofore accrued; and in all events, Tenant shall look solely to the Premises and rents derived therefrom for enforcement of any obligation hereunder or by law assumed or enforceable against Landlord or such other person. Any sale or other transfer by Landlord of all or any portion of its interest in the Property and/or in this Lease shall be conditioned upon the agreement of such transferee to assume all of Landlord's obligations hereunder and to accept such transfer subject to all terms and conditions of this Lease and Tenant's rights hereunder. The word "Tenant" is used herein to include the party named above as Tenant as well as its or their respective heirs, personal representatives, successors and assigns, each of whom shall be under the same obligations, liabilities and disabilities and have only such rights, privileges and powers as he would have possessed had he originally signed this Lease as Tenant.

33. ENTIRE AGREEMENT; INTERPRETATION:

This Lease constitutes the entire agreement between the parties hereto with respect to the Premises and there are no other agreements or understandings. This Lease shall not be modified except by written instrument executed by both parties. The captions used herein are for convenience only, and are not part of the Lease. This Lease shall be construed in accordance with the laws of the Commonwealth of Pennsylvania. Exhibits "A", "B", "C",

"D", and "E" are attached hereto and made a part hereof.

34. SUBMISSION OF LEASE TO TENANT:

The submission by Landlord to Tenant of this Lease shall have no binding force or effect, shall not constitute an option for the leasing of the Premises, shall not constitute a lease or agreement to enter in to a lease (even if such term is less than three (3) years in duration), nor confer any rights or impose any obligations upon either party until the execution thereof by Landlord and Tenant and the delivery of an executed original copy thereof by Landlord to Tenant or Tenant's representative.

35. GUARANTY:

In consideration of the execution of this Lease by Landlord, Tenant agrees to cause K12 Virtual Schools LLC ("Guarantor") to guarantee the prompt payment and performance of all of Tenant's obligations during the Initial Term of the Lease. Such Guaranty shall be in the form attached hereto as Exhibit "E".

36. CONFESSION OF JUDGMENT:

(A) TENANT HEREBY AUTHORIZES AND EMPOWERS THE PROTHONOTARY, CLERK OF COURT OR ANY ATTORNEY OF ANY COURT OF RECORD IN THIS COMMONWEALTH OR ELSEWHERE TO APPEAR FOR TENANT UPON OR AFTER THE EXPIRATION OF THE TERM OF THIS LEASE (OR ANY EXTENSION PERIOD), OR UPON OR AFTER THIS LEASE HAS TERMINATED ON ACCOUNT OF ANY EVENT OF DEFAULT ON THE PART OF TENANT HEREUNDER, TO APPEAR AS ATTORNEY FOR TENANT AS WELL AS FOR ALL PERSONS CLAIMING BY, THROUGH OR UNDER TENANT, AND THEREIN TO CONFESS JUDGMENT IN EJECTMENT FOR POSSESSION OF THE PREMISES HEREIN DESCRIBED, FOR WHICH THIS LEASE AND THE APPOINTMENTS HEREIN SHALL BE SUFFICIENT WARRANT; THEREUPON, IF LANDLORD SO DESIRES, AN APPROPRIATE WRIT OF POSSESSION MAY ISSUE FORTHWITH, WITHOUT ANY PRIOR WRIT OR PROCEEDING WHATSOEVER, AND PROVIDED THAT IF FOR ANY REASON AFTER SUCH ACTION SHALL HAVE BEEN COMMENCED IT SHALL BE DETERMINED THAT POSSESSION OF THE PREMISES SHOULD REMAIN IN OR BE RESTORED TO TENANT, LANDLORD SHALL HAVE THE RIGHT FOR THE SAME DEFAULT AND UPON ANY SUBSEQUENT EVENT OR EVENTS OF DEFAULT, OR UPON THE TERMINATION OF THIS LEASE OR OF TENANT'S RIGHT OF POSSESSION AS HEREINBEFORE SET FORTH, TO BRING ONE OR MORE FURTHER ACTIONS AS HEREINBEFORE SET FORTH TO RECOVER POSSESSION OF THE PREMISES AND TO CONFESS JUDGMENT FOR THE RECOVERY OF POSSESSION OF THE PREMISES BY LANDLORD AS HEREINBEFORE PROVIDED. THE FOREGOING WARRANT SHALL NOT BE EXHAUSTED BY ANY ONE EXERCISE THEREOF BUT SHALL BE EXERCISABLE FROM TIME TO TIME AND AS OFTEN AS THERE IS ANY ONE

OR MORE EVENTS OF DEFAULT OR WHENEVER THIS LEASE AND THE TERM OR ANY EXTENSION OR RENEWAL THEREOF SHALL HAVE EXPIRED, OR TERMINATED ON ACCOUNT OF ANY EVENT OF DEFAULT BY TENANT HEREUNDER. THE TENANT AGREES THAT THE POWER TO CONFESS JUDGMENT GRANTED BY THIS PARAGRAPH IS COUPLED WITH AN INTEREST, AND IS THEREFORE IRREVOCABLE.

IN ANY SUCH ACTION, A TRUE COPY OF THIS LEASE SHALL BE SUFFICIENT WARRANT, AND IT SHALL NOT BE NECESSARY TO FILE THE ORIGINAL AS A WARRANT OF ATTORNEY, ANY RULE OF COURT, CUSTOM OR PRACTICE TO THE CONTRARY NOTWITHSTANDING.

TENANT ACKNOWLEDGES AND AGREES THAT THIS LEASE CONTAINS PROVISIONS UNDER WHICH LANDLORD MAY ENTER JUDGMENT BY CONFESSION AGAINST TENANT. BEING FULLY AWARE OF TENANT'S RIGHTS TO PRIOR NOTICE AND A HEARING ON THE VALIDITY OF ANY JUDGMENT OR OTHER CLAIMS THAT MAY BE ASSERTED AGAINST TENANT BY LANDLORD HEREUNDER BEFORE JUDGMENT IS ENTERED, TENANT HEREBY FREELY, KNOWINGLY AND INTELLIGENTLY WAIVES THESE RIGHTS AND EXPRESSLY AGREES AND CONSENTS TO LANDLORD'S ENTERING JUDGMENT AGAINST TENANT BY CONFESSION PURSUANT TO THE TERMS OF THIS LEASE.

(B) TENANT ALSO ACKNOWLEDGES AND AGREES THAT THIS LEASE CONTAINS PROVISIONS UNDER WHICH LANDLORD MAY, AFTER ENTRY OF JUDGMENT AND WITHOUT EITHER NOTICE OR A HEARING, FORECLOSE UPON, ATTACH, LEVY OR OTHERWISE SEIZE PROPERTY (REAL OR PERSONAL) OF THE UNDERSIGNED IN FULL OR PARTIAL PAYMENT OR OTHER SATISFACTION OF THE JUDGMENT. BEING FULLY AWARE OF TENANT'S RIGHTS AFTER JUDGMENT IS ENTERED (INCLUDING THE RIGHT TO MOVE OR PETITION TO OPEN OR STRIKE THE JUDGMENT), THE UNDERSIGNED HEREBY FREELY, KNOWINGLY AND INTELLIGENTLY WAIVES THESE RIGHTS AND EXPRESSLY AGREES AND CONSENTS TO LANDLORD'S TAKING SUCH ACTIONS AS MAY BE PERMITTED UNDER APPLICABLE STATE AND FEDERAL LAW, AND ACKNOWLEDGES THAT THE LANDLORD MAY CAUSE PROPERTY OF THE TENANT TO BE SEIZED AND SOLD WITHOUT PRIOR NOTICE TO TENANT. WITHOUT LIMITING THE

FOREGOING, TENANT SPECIFICALLY WAIVES THE NOTICES AND NOTICE REQUIREMENTS OF RULES 2956.1, 2958.1, 2958.2, 2958.3, 2973.1, 2973.2, AND 2973.3.

INSIGHT PA CYBER CHARTER SCHOOL

Witness: Myra J. Jode
Name: Myra Jode

By: Edward P. Kelly
Name: ~~Michael Adler~~ Edward P. Kelly
Title: ^{Vice} President & Treasurer

[Signatures on Following Page]

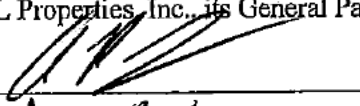
IN WITNESS WHEREOF, the parties hereto have executed this Lease, under seal, as of the day and year first above written.

LANDLORD:

SBH ASSOCIATES, L.P.

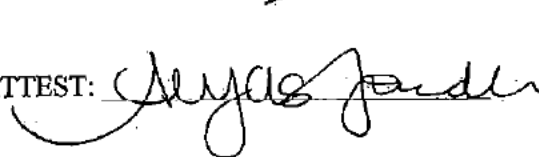
By JRL Properties, Inc., its General Partner

ATTEST: 

By: 
Name: ADAM R. LOEW
Title: PRESIDENT
Date: 8-29-17

TENANT:

INSIGHT PA CYBER CHARTER SCHOOL

ATTEST: 


By: 
Name: ~~Michael Adler~~ Edward P. Kelly
Title: ~~President~~ Vice President/Treasurer
Date: 8/23/2017

EXHIBIT "A"

Premises

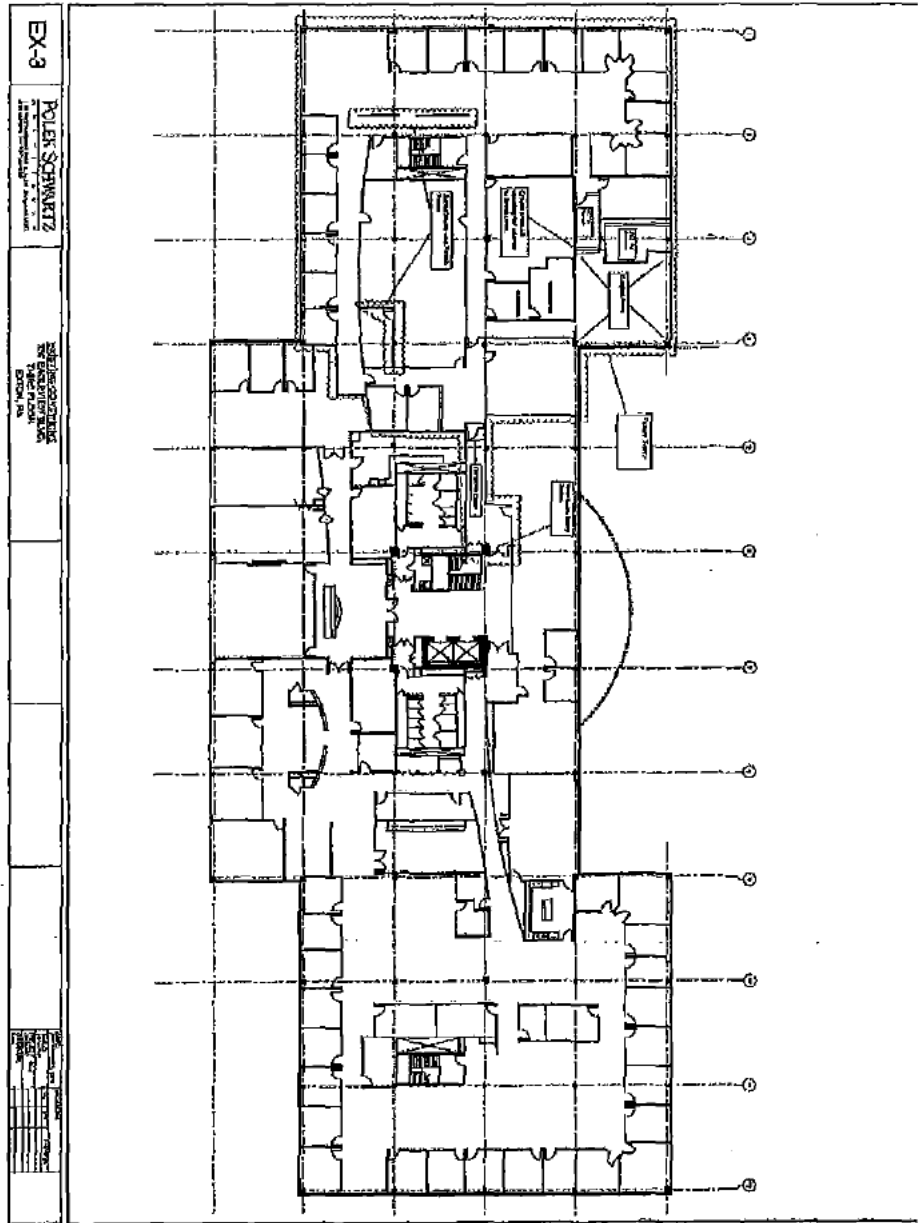


EXHIBIT "B"

Landlord's Work Plans

LANDLORD'S WORK: Landlord shall provide, at no cost to Tenant, the following work (collectively Landlord's Work) to the Premises and the building per Landlord's plans and specifications, and in compliance with all applicable building code requirements. The space is comprised of +/- 14,862 RSF.

I. HVAC:

- a.) The existing HVAC system within the tenants +/- 14,862 RSF on the 3rd floor will remain as is and be in working condition to adequately heat and cool the space for tenant usage.
- b.) The existing thermostat locations are to remain in their current locations.
- c.) No modifications to the existing HVAC system will take place as a part of the landlord work.

II. VOICE & DATA CABLING:

- a.) Voice & Data Cabling and existing terminations will remain in place where existing for the tenant's use.
- b.) The landlord does not warrant the cabling in place or cover and deficiencies for the existing cabling that is in place.

III. ELECTRICAL:

- a.) All existing electrical outlets will be active with power upon turnover of the space to the tenant.
- b.) All existing light fixtures will be in working conditions and any missing or dead light bulbs will be replaced within the space prior to tenant occupancy.
- c.) Adequate lighting will be provided at the entry hallway and throughout the tenant's suite.

IV. PLUMBING:

- a.) All existing pantry plumbing will remain operational for the tenants use in the pantry area.
- b.) No additional plumbing will be added to the space as part of this work letter.

V. SELECTIVE DEMOLITION:

- a.) All walls indicated on the floor plan attached to this lease (Approx. 4 locations) are to be demolished to the ceiling grid leaving a 1" soffit reveal which will be finished and painted to match the ceiling color.

- b.) All doors indicated on the floor plan attached to this lease and shown in yellow (Approx. 2 locations) are to be demolished and the door, hardware and frames are to be removed. The opening will be repaired and painted to match the surrounding walls.

VI. FLOORS:

- a.) The landlord to provide and install at the tenant's selection a commercial grade carpet of up to \$30 per Square Yard that is quick ship in nature to hit the space delivery of September 1st, 2017.
- b.) The landlord will provide and install a 4'' rubber base with a toe for both the opened office and the pantry area. Final color to be selected by the tenant.

VII. SUITE ENTRY:

- a.) The landlord will provide a single 6'x 8' Herculite or equal cleat tempered frameless glass door with 4'' high beveled top and bottom rail with (1) stainless steel pull on each of the double doors.
- b.) The front entry door will be locking with a bolt action lock at the bottom 4'' rail (keyed outside, twist lock inside).

VIII. PAINTING:

- a.) Clean, touch up, patch and repair all existing walls, partitions, columns, perimeter windows, frames required prior to applying new paint.
- b.) (2) finish coats of Benjamin Moore (or equal) paint to be provided to adequately cover the existing walls with an eggshell finish, color to be selected and provided by the tenant.
- c.) All office doors are to remain unpainted.

IX. FIRE PROTECTION:

- a.) Fire sprinkler lines to remain and provide adequate coverage to meet code compliance within the tenant space.
- b.) Existing speakers and strobes are to remain to provide adequate coverage to meet code compliance within the tenant space.

X. SIGNAGE:

- a.) The landlord will provide (1) tenant entry suite sign immediately outside the tenant's entry doors to the suite that is consistent with the other tenant signage through the building.
- b.) Code compliant signage will be supplied and installed as part of the landlord work as required.

Landlord Exclusions:

- Voice & Data Cabling above and beyond what is existing in the tenant's space currently as well as the running, testing, tuning and patching of any other associated cabling work are excluded.
- Demolition of any walls, doors, ceilings, finishes and cabling above and beyond the scope outlined in the work letter is excluded.
- Tenant Security at both the tenant suite entry doors and within the tenant space is excluded.
- Furniture, fixtures, appliances and equipment are excluded.
- Signage (Exterior and Interior) above and beyond the indicated signage within this work letter are excluded.
- Internet service(s) and phone systems are excluded.
- Additional permittable work above and beyond what is outlined in this work letter is excluded.
- Architectural, Engineering or Structural design is excluded.

EXHIBIT "C"

ESTOPPEL CERTIFICATE

Re: That certain Lease dated _____, 20 __, by and between _____, a _____, as **Landlord**, and _____, a _____, as **Tenant** for a _____ (_____) year term which commenced on _____, 20 __, and will terminate on _____, 20 __, (the **Lease**) of the premises commonly referred to as Suite _____ containing _____ rentable square feet of the building (the **Leased Premises**) commonly known as _____ (the **Project**).

Gentlemen:

Tenant hereby certifies that the above description of the Lease, and the description of the Leased Premises therein demised, is a true and correct description of the same and that the Lease constitutes the only agreement between Landlord and Tenant with respect to the Leased Premises.

Tenant hereby certifies, acknowledges and agrees as follows:

1. Tenant's monthly rent under the Lease is \$ _____.
2. Tenant's payment to Landlord for Operating Expenses under the Lease is currently \$ _____ per _____.
3. Tenant's last payment of rent was made for the rental payment due _____.
4. No rent has been paid by Tenant in advance under the Lease except for _____ and Tenant has no claim of offset or credits against rentals under the Lease except for _____.
5. A security deposit of \$ _____ has been made with Landlord.
6. Tenant is entitled to the following renewal options under the Lease:
_____.

7. The following uncompleted tenant improvement work on the Leased Premises is required to be performed by [Tenant] [Landlord]:
8. Except as provided below, the Lease is in full force and effect, Tenant has accepted the Leased Premises, presently occupies the same, and is paying rent on a current basis, to the best of Tenant's knowledge, Tenant has no set-offs, claims, or defenses to the enforcement of the Lease, and there are no periods of free rental applicable to the term of the Lease except: _____.
9. Tenant hereby represents and warrants to Lender that, other than those contained in writing in the Lease, there have been no representations, warranties or covenants made by Landlord to Tenant, either oral or in writing.
10. Tenant is not in default in the performance of the Lease, has not committed any breach of the Lease, no notice of default has been given to Tenant, and Tenant is not the subject of any federal or state, bankruptcy, insolvency or liquidation proceeding except: _____.
11. To the best of Tenant's knowledge, Landlord is not in default in the performance of the Lease, has not committed any breach of the Lease, no notice of default has been given to Landlord, and Landlord has fulfilled all representations and warranties and all finish work on the Leased Premises required of Landlord as of the date hereof except: _____.
12. There have been no amendments, modifications, extensions or renewals of the Lease except as follows:
13. To the best of Tenant's knowledge, its use of the Leased Premises during its lease term has complied and will continue to comply with all applicable federal, state and local laws, rules and regulations, including environmental and life safety laws, rules and regulations.

Very truly yours,

By: _____
Its: _____

EXHIBIT "D"

CLEANING SPECIFICATIONS

General cleaning: five nights per week, Monday through Friday.

DAILY:

1. Empty waste receptacles and remove to designated area for pick up.
2. Dust and/or damp wipe clean the following when clear of personal property: doors; chairs; pushplates; window sills; tables and lamps; file and storage cabinets; counters, ledges, and shelves.
3. Spot vacuum all areas as needed.
4. Special attention will be given to the Executive areas and Conference rooms.
5. Wash, clean and disinfect all water fountains and/or coolers.
6. Wash front door glass, as well as the adjacent architectural metal trim, to remove fingerprints, smudges, etc., caused during the day.
7. Special attention will be given to the lobby, reception and other public areas. All furniture will be hand wiped and carpets thoroughly vacuumed.
8. Sweep all resilient tile floor coverings with chemically-treated dry mop. Spot mop to remove soilage.
9. Extinguish all interior lights unless otherwise notified. Night and safety lights will be operated as instructed. All doors will be locked and secured and any doors that are not functioning will be reported by the night supervisor.
10. Lavatories:
 - a. Sweep and wet mop floors.
 - b. Polish all mirrors, bright work and enameled surfaces.
 - c. Wash and disinfect all basins, bowls and urinals.
 - d. Hand dust and clean all partitions, tops of tile ledges, all towel, paper and sanitary napkin dispensers.
 - e. Refill all toilet tissue, soap, and towel dispensers (towels, tissues, hand soap, etc., to be supplied by Landlord).

WEEKLY:

1. Spot clean doors, glass partitions and electric switch plates. Glass doors will be washed.
2. High dust all horizontal surfaces above the reach of the average person, (such as door frames, partitions, ledges, etc.).
3. All carpeted areas will be thoroughly vacuumed.
4. Remove fingerprints and scuff marks from all vertical surfaces within the reach of the average person.

MONTHLY:

1. Spray buff all resilient tile floors.

QUARTERLY:

1. Dust venetian blinds.

SEMI-ANNUALLY:

1. Wash windows inside and outside.

EXHIBIT "E"

GUARANTY

(See Following Pages)

GUARANTY

This Guaranty is executed and delivered this 24th day of August, 2017 by K12 Virtual Schools LLC, a Delaware limited liability company (herein collectively, "Guarantor") in favor of SBH Associates, L.P, a Pennsylvania limited partnership ("Landlord").

RECITALS:

WHEREAS, Insight PA Cyber Charter School, a Pennsylvania nonprofit corporation ("Tenant"), and Landlord are party to that certain Lease dated of the same date ("Lease") for the lease of Suite 350 in that certain office building located at 350 Eagleview Boulevard, Exton, PA;

WHEREAS, In order to induce Landlord to enter into the Lease, Guarantor agreed to execute and deliver to Landlord this Guaranty.

WHEREAS, Guarantor acknowledges that Landlord would not have entered into the Lease without the execution and delivery by Guarantor of this Guaranty.

NOW THEREFORE, of Landlord's agreement to execute the Lease and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Guarantor does hereby agree with Landlord as follows:

1. Subject to applicable notice and cure periods, during the time period defined in the final sentence of this Section 1, Guarantor shall unconditionally and irrevocably guarantee and act as surety for: (i) the prompt payment by Tenant of the Base Rent, additional rent and other sums of money which at any time shall become due and payable under the Lease; and (ii) the due and prompt performance of all of the terms, agreements and covenants of the Lease (collectively, "Guaranteed Obligations"), except that the Guaranteed Obligations shall not include any liability for any events which are covered or should have been covered by insurance policies that Landlord was obligated to obtain under the Lease. This Guaranty shall expire at the earliest of: (a) the end of the Initial Term, as that term is defined in the Lease; (b) five (5) years after the Commencement Date as that term is defined in the Lease; or (c) the earlier termination of the Lease. Subject to Section 2 below, Guarantor further acknowledges that Landlord may proceed directly against Guarantor immediately following any default by Tenant under the Lease or at any time thereafter, whether or not Landlord elects to pursue any remedy against Tenant under the Lease or otherwise.

2. Upon any default by Tenant under the Lease, and after the expiration of all applicable notice and cure periods, Landlord may proceed directly against Guarantor to collect and recover the full amount of the liability outstanding at the time of such default, hereunder or any portion thereof, without proceeding first against Tenant and without resorting to any property Landlord may be holding as security for Tenant's obligations under the Lease, provided Landlord has delivered a copy of the applicable notice of Tenant's default to Guarantor as required under Section 1 of the Lease. Notwithstanding anything to the contrary herein, Guarantor shall have no greater liability under this Guaranty for Tenants' obligations, or otherwise, than the obligations, agreements, duties and covenants of Tenant specifically set forth in the Lease, except in the case of Guarantor's breach of this Guaranty.

3. Guarantor agrees that any notice or demand upon them shall be deemed sufficiently given or served if in writing and either personally delivered or mailed by overnight mail by a nationally recognized overnight courier furnishing a written record of actual or attempted delivery or by Unites States Mail, certified or registered, return receipt requests, in all cases with postage fully pre-paid and address to Guarantor at:

K12 Virtual Schools LLC
2300 Corporate Park Drive
Herndon, VA 20171
Attn: Facilities Manager

With a copy to

K12 Virtual Schools LLC
2300 Corporate Park Drive
Herndon, VA 20171
Attn: General Counsel

4. Guarantor agrees that this guaranty shall remain in full force and effect notwithstanding that, (i) there has been any modification of the Lease; (ii) the Lease has been assigned by Tenant or any portion of the Premises has been sublet; (iii) any property held as security for Tenant's obligations under the Lease has been released or exchanged; or (iv) any indulgence or forbearance has been granted to Tenant under the Lease.

5. The validity of this Guaranty shall not be impaired by reason of Landlord's failure to exercise, or delay in exercising any right or remedy Landlord may have under this Guaranty.

6. This Guaranty may be amended only by written agreement signed by Landlord and Guarantor.

7. This Guaranty shall inure to the benefit of and shall be binding upon Landlord and Guarantor and their respective legal representatives, heirs, successors and assigns.

THIS GUARANTY SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE INTERNAL LAWS OF THE COMMONWEALTH OF PENNSYLVANIA WITHOUT GIVING EFFECT TO PRINCIPLES OF CONFLICTS OF LAW. GUARANTOR AND LANDLORD JOINTLY AND SEVERALLY AGREE TO THE EXCLUSIVE JURISDICTION OF COURTS LOCATED IN THE COMMONWEALTH OF PENNSYLVANIA, UNITED STATES OF AMERICA, OVER ANY DISPUTES ARISING OR RELATING TO THIS GUARANTY.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE TERMS AND CONDITIONS CONTAINED IN THIS GUARANTY.

[Signature Page Follows]

IN WITNESS WHEREOF, this Guaranty has been executed and delivered as of the date and year first above written.

GUARANTOR:

K12 Virtual Schools LLC
a Delaware corporation


By: 
Print Name: James Rhyu
Title: Executive Vice President
Chief Financial Officer

EXHIBIT "F"

(Amortization Schedule)

To be confirmed upon final construction no later than September 30, 2017.

FIRST AMENDMENT TO LEASE AGREEMENT

THIS FIRST AMENDMENT TO LEASE AGREEMENT (the "First Amendment") is made this 17th day of June, 2019, between SBH ASSOCIATES, L.P., a Pennsylvania limited partnership ("Landlord") and INSIGHT PA CYBER CHARTER SCHOOL, a Pennsylvania corporation ("Tenant").

WITNESSETH

A. Landlord and Tenant are parties to a certain Lease Agreement dated August 29, 2017 (the "Lease"), pursuant to which Landlord currently leases to Tenant certain premises consisting of approximately 14,862 square feet of space (the "Existing Premises") in Suite 350 of that three-story office building (the "Building") located at 350 Eagleview Boulevard, Exton, Pennsylvania, as more particularly described in the Lease. All capitalized terms not otherwise defined herein shall have the meanings given to those terms in the Lease.

B. Tenant now desires to expand the Existing Premises by leasing from Landlord certain premises in the Building consisting of approximately 2,977 square feet of space (the "Additional Premises"), and Landlord desires to lease to Tenant the Additional Premises upon the terms and conditions set forth herein. The Additional Premises is shown on the plan attached hereto as Exhibit "A".

NOW, THEREFORE, in consideration of the foregoing recitals which are true and correct and are incorporated into this First Amendment as if set forth herein at length, and the covenants and conditions set forth herein, the parties hereto, intending to be legally bound, hereby agree that the Lease is hereby amended and supplemented as follows:

1. **Additional Premises.** Effective as of August 1, 2019 (the "Effective Date"), Landlord hereby leases to Tenant, and Tenant hereby accepts from Landlord, the Additional Premises to be used by Tenant solely for the uses permitted in the Lease. All terms and conditions of the Lease (as amended hereby) shall apply to the Additional Premises except: (x) as specifically set forth herein; (y) Tenant's Proportionate Share shall be increased to 14.62%, and all other figures in the Lease affected by the addition of such square footage shall be adjusted accordingly; and (z) Tenant shall not be entitled to any allowances, credits, options or other concessions with respect to the Additional Premises except as specifically set forth herein. From and after the Effective Date, all references in the Lease to the "Demised Premises" shall be deemed to include the Additional Premises. The Additional Premises and the Existing Premises shall be collectively referred to herein as the "New Premises" which consists of approximately 17,839 square feet.

2. **Term.** The term of the Lease for the Additional Premises shall commence on the Effective Date and shall expire on August 31, 2023 (the "Additional Premises Expiration Date", and the period between the Effective Date and the Additional Premises Expiration Date is hereinafter referred to as the "Expansion Term"). In addition, the term of the Lease with respect to the Existing Premises, which currently is set to expire on August 31, 2022, shall be extended for an additional year so as to also

expire on the Additional Premises Expiration Date. Notwithstanding the foregoing, Tenant shall continue to have the right to exercise the Option to Extend set forth in the Lease as it relates to the Term and the Existing Premises, and said Option to Extend shall also apply to the Expansion Term and the Additional Premises, all in accordance with the terms and conditions set forth in the Lease for said Option to Extend, except that Tenant shall be required to give Landlord written notice of its election to exercise the Option to Extend at least nine (9) months prior to the Additional Premises Expiration Date defined above, or the Option to Extend will automatically terminate.

3. **Annual Base Rent.** Effective as of the Effective Date, the Base Rent for the New Premises in the following amounts for the following periods shall be due on the first day of each calendar month throughout the Expansion Term, as follows:

<u>Lease Year</u>	<u>Base Rent</u>	<u>Monthly Installment</u>	<u>Per Square Foot</u>
8/1/19-8/31/19*	\$379,078.75	\$31,589.90	\$21.25
9/1/19-8/31/20	\$387,998.25	\$32,333.19	\$21.75
9/1/20-8/31/21	\$396,917.75	\$33,076.48	\$22.25
9/1/21-8/31/22	\$405,837.25	\$33,819.77	\$22.75
9/1/22-8/31/23	\$414,756.75	\$34,563.06	\$23.25

*Notwithstanding the foregoing, Base Rent for the New Premises shall be abated for the months of August, September, October, November and December of 2019, but Tenant shall be liable for the payment of utilities for the New Premises and costs of janitorial services for the New Premises during such months. The Base Rent shall be payable in equal monthly installments at the times and in the manner for the payment of the Base Rent as set forth in the Lease. Tenant shall be responsible for (i) Tenant's Proportionate Share of all Operating Expenses, and (ii) gas, electric and all other utilities consumed in the New Premises as provided in the Lease. The Base Year, with respect to the Additional Premises, shall be as set forth in the Lease for the Existing Premises. The term "**Expansion Lease Year**" shall mean each consecutive period of twelve (12) months commencing on the Effective Date, and each subsequent Expansion Lease Year shall be each consecutive period of twelve (12) months thereafter.

4. **Condition of Additional Premises.** Landlord shall construct the improvements within the Additional Premises described and/or depicted on the plans and specifications attached hereto as **Exhibit "B"** ("**Landlord's Expansion Work**"), but in no event shall Landlord be obligated to incur Costs (as hereinafter defined) to construct Landlord's Expansion Work in excess of \$30,000.00 (the "Allowance"). Tenant shall be responsible for all Costs in excess of the Allowance. "Costs" shall mean all "hard" and "soft" costs to construct Landlord's Expansion Work. "Hard" costs shall include the actual costs of labor and materials in the construction of Landlord's Expansion Work, including contractor profit, overhead and general conditions. "Soft" costs shall include all costs other than "hard" costs, including, without limitation, design, engineering and architect's fees, permit fees and inspection fees. Upon completion of Landlord's Expansion Work, Landlord shall submit to Tenant a statement of the actual Costs incurred by Landlord. If the actual Costs exceed the Allowance, Tenant shall pay such additional amount to Landlord within ten (10) days after receipt of such statement. If the

actual Costs are less than the Allowance, Tenant shall not be entitled to any payment, refund or credit of such excess Allowance amount. If Tenant requests, and Landlord approves, any changes to the plans for Landlord's Expansion Work, Tenant shall be responsible for one hundred percent (100%) of the costs to implement such change, including any costs resulting from delays in Landlord's Expansion Work, and Tenant shall pay such excess Costs to Landlord as a condition to Landlord's obligation to construct such change. Other than Landlord's Expansion Work, Tenant has inspected the Additional Premises, is familiar with the condition thereof, and accepts the Additional Premises in its "AS-IS" condition, without any representation or warranty by Landlord, express or implied. Other than Landlord's Expansion Work, Tenant acknowledges that Landlord shall have no obligation to construct any improvements or alterations, or to extend or provide any services (including, without limitation, utility services) on or to the Additional Premises or the Existing Premises or to or for the benefit of Tenant, or to make any repairs or replacements to the Additional Premises or the Existing Premises; and Landlord makes no warranty concerning the Additional Premises or the Existing Premises, including without limitation any warranties of merchantability, habitability, fitness or any other condition thereof for any particular purpose. Notwithstanding anything to the contrary contained in the Lease, Landlord shall not be liable in any manner to Tenant for damages or any other claim resulting from failure to deliver the Additional Premises and Tenant hereby waives all such liability.

5. **Tenant's Work to the Additional Premises.** If Tenant desires to perform any work in the Additional Premises, Tenant shall, at Tenant's sole cost and expense, submit to Landlord for Landlord's written approval, detailed construction and working drawings of the work to be performed by Tenant to the Additional Premises to prepare the Additional Premises for business to be conducted therefrom (collectively, the "Tenant's Work"), which drawings shall be prepared by a licensed architect reasonably satisfactory to Landlord. Tenant may not commence Tenant's Work unless and until Landlord has approved such plans, and Tenant obtains all permits and approvals therefor. Tenant shall perform all of the Tenant's Work in a good and workmanlike manner and otherwise in accordance with the Lease.

6. **Early Termination.** As of the Effective Date, the First Termination Right and the Second Termination Right granted to Tenant pursuant to the Lease shall be null and void and of no further force or effect; however, the Third Termination Right, effective as of the last day of the 108th full month after the original Commencement Date under the Lease (said Commencement Date being, September 1, 2017) (assuming that Tenant has exercised the Option to Extend), shall remain in full force and effect and shall be governed by the terms of the Lease as set forth therein.

7. **Guaranty.** Landlord and Tenant hereby acknowledge that K12 Virtual Schools LLC executed a Lease Guaranty on August 28, 2017, guaranteeing the prompt payment and performance of all of Tenant's obligations under the Lease until the earlier of: (a) the expiration of the Initial Term of the Lease; (b) five (5) years after the Commencement Date as that term is defined in the Lease; or (c) the earlier termination of the Lease. The Lease Guaranty is hereby amended to continue to remain in full force and effect until the earlier of: (a) the Additional Premises Expiration Date, as that term is defined in this Amendment; (b) six (6) years after the Commencement Date as that term is defined in the Lease; or (c) the earlier termination of the Lease.

8. **Certification.** Tenant, by executing this First Amendment, hereby certifies that: (a) the Lease is in full force and effect and has not been modified except as provided above; (b) there are no prepayments by or credits due to Tenant under the Lease; and (c) Tenant is not aware of the existence of any default by Landlord, nor of any event which with the giving of notice or passage of time, or both, would constitute a breach or default by Landlord under the Lease.

9. **Broker.** Tenant and Landlord warrant that they have had no dealings with any broker or agent in connection with the negotiations or execution of this First Amendment, and Landlord and Tenant agree to indemnify the other against all costs, expenses, attorney's fees, or other liability for commissions or other compensation or charges resulting from a breach of such representations.

10. **Entire Agreement/Ratification.** This First Amendment represents the entire understanding of the parties with respect to the subject matter hereof, and the Lease as hereby amended remains in full force and effect and may not be modified further except in writing executed by the parties to be bound thereby. Unless expressly modified herein, the terms and conditions of the Lease shall continue in full force and effect, and the parties hereby confirm and ratify the same.

11. **Miscellaneous.** This First Amendment shall be binding upon and shall inure to the benefit of the parties and their successors and assigns.

12. **CONFESSION OF JUDGMENT.**

(A) TENANT HEREBY AUTHORIZES AND EMPOWERS THE PROTHONOTARY, CLERK OF COURT OR ANY ATTORNEY OF ANY COURT OF RECORD IN THIS COMMONWEALTH OR ELSEWHERE TO APPEAR FOR TENANT UPON OR AFTER THE EXPIRATION OF THE EXPANSION TERM (OR ANY EXTENSION PERIOD), OR UPON OR AFTER THIS LEASE HAS TERMINATED ON ACCOUNT OF ANY EVENT OF DEFAULT ON THE PART OF TENANT HEREUNDER, TO APPEAR AS ATTORNEY FOR TENANT AS WELL AS FOR ALL PERSONS CLAIMING BY, THROUGH OR UNDER TENANT, AND THEREIN TO CONFESS JUDGMENT IN EJECTMENT FOR POSSESSION OF THE NEW PREMISES HEREIN DESCRIBED, FOR WHICH THIS LEASE AND THE APPOINTMENTS HEREIN SHALL BE SUFFICIENT WARRANT; THEREUPON, IF LANDLORD SO DESIRES, AN APPROPRIATE WRIT OF POSSESSION MAY ISSUE FORTHWITH, WITHOUT ANY PRIOR WRIT OR PROCEEDING WHATSOEVER, AND PROVIDED THAT IF FOR ANY REASON AFTER SUCH ACTION SHALL HAVE BEEN COMMENCED IT SHALL BE DETERMINED THAT POSSESSION OF THE NEW PREMISES SHOULD REMAIN IN OR BE RESTORED TO TENANT, LANDLORD SHALL HAVE THE RIGHT FOR THE SAME DEFAULT AND UPON ANY SUBSEQUENT EVENT OR EVENTS OF DEFAULT, OR UPON THE TERMINATION OF THIS LEASE OR OF TENANT'S RIGHT OF POSSESSION AS HEREINBEFORE SET FORTH, TO BRING ONE OR MORE FURTHER ACTIONS AS HEREINBEFORE SET FORTH TO RECOVER POSSESSION OF THE NEW PREMISES AND TO CONFESS JUDGMENT FOR THE RECOVERY OF POSSESSION OF THE NEW PREMISES BY LANDLORD AS HEREINBEFORE PROVIDED. THE

FOREGOING WARRANT SHALL NOT BE EXHAUSTED BY ANY ONE EXERCISE THEREOF BUT SHALL BE EXERCISABLE FROM TIME TO TIME AND AS OFTEN AS THERE IS ANY ONE OR MORE EVENTS OF DEFAULT OR WHENEVER THIS LEASE AND THE EXPANSION TERM OR ANY EXTENSION OR RENEWAL THEREOF SHALL HAVE EXPIRED, OR TERMINATED ON ACCOUNT OF ANY EVENT OF DEFAULT BY TENANT HEREUNDER. TENANT AGREES THAT THE POWER TO CONFESS JUDGMENT GRANTED BY THIS PARAGRAPH IS COUPLED WITH AN INTEREST, AND IS THEREFORE IRREVOCABLE.

IN ANY SUCH ACTION, A TRUE COPY OF THIS LEASE SHALL BE SUFFICIENT WARRANT, AND IT SHALL NOT BE NECESSARY TO FILE THE ORIGINAL AS A WARRANT OF ATTORNEY, ANY RULE OF COURT, CUSTOM OR PRACTICE TO THE CONTRARY NOTWITHSTANDING.

TENANT ACKNOWLEDGES AND AGREES THAT THIS LEASE CONTAINS PROVISIONS UNDER WHICH LANDLORD MAY ENTER JUDGMENT BY CONFESSION AGAINST TENANT. BEING FULLY AWARE OF TENANT'S RIGHTS TO PRIOR NOTICE AND A HEARING ON THE VALIDITY OF ANY JUDGMENT OR OTHER CLAIMS THAT MAY BE ASSERTED AGAINST TENANT BY LANDLORD HEREUNDER BEFORE JUDGMENT IS ENTERED, TENANT HEREBY FREELY, KNOWINGLY AND INTELLIGENTLY WAIVES THESE RIGHTS AND EXPRESSLY AGREES AND CONSENTS TO LANDLORD'S ENTERING JUDGMENT AGAINST TENANT BY CONFESSION PURSUANT TO THE TERMS OF THIS LEASE.

(B) TENANT ALSO ACKNOWLEDGES AND AGREES THAT THIS LEASE CONTAINS PROVISIONS UNDER WHICH LANDLORD MAY, AFTER ENTRY OF JUDGMENT AND WITHOUT EITHER NOTICE OR A HEARING, FORECLOSE UPON, ATTACH, LEVY OR OTHERWISE SEIZE PROPERTY (REAL OR PERSONAL) OF THE UNDERSIGNED IN FULL OR PARTIAL PAYMENT OR OTHER SATISFACTION OF THE JUDGMENT. BEING FULLY AWARE OF TENANT'S RIGHTS AFTER JUDGMENT IS ENTERED (INCLUDING THE RIGHT TO MOVE OR PETITION TO OPEN OR STRIKE THE JUDGMENT), THE UNDERSIGNED HEREBY FREELY, KNOWINGLY AND INTELLIGENTLY WAIVES THESE RIGHTS AND EXPRESSLY AGREES AND CONSENTS TO LANDLORD'S TAKING SUCH ACTIONS AS MAY BE PERMITTED UNDER APPLICABLE STATE AND FEDERAL LAW, AND ACKNOWLEDGES THAT LANDLORD MAY CAUSE PROPERTY OF TENANT TO BE SEIZED AND SOLD WITHOUT PRIOR NOTICE TO TENANT. WITHOUT LIMITING THE FOREGOING, TENANT SPECIFICALLY WAIVES THE NOTICES AND NOTICE REQUIREMENTS OF RULES 2956.1, 2958.1, 2958.2, 2958.3, 2973.1, 2973.2, AND 2973.3.

INSIGHT PA CYBER CHARTER SCHOOL

Witness: *M Chacania*
Name: *Juanita Chacania*

By: *Beth Jones*
Name: *Beth Jones*

Title: CFO

[SIGNATURE PAGE TO FOLLOW]


IN WITNESS WHEREOF, the parties hereto have executed this First Amendment as of the day and year first above written.

LANDLORD:

SBH ASSOCIATES, L.P.

By JRL Properties, Inc., its General Partner

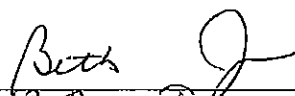
ATTEST: 

By: 
Name: Adam R. Loew
Title: President
Date: 7/17/19

TENANT:

INSIGHT PA CYBER CHARTER SCHOOL

ATTEST: 

By: 
Name: Beth Jones
Title: CFO
Date: 7/17/2019

GUARANTOR, K12 VIRTUAL SCHOOLS LLC, HEREBY ACKNOWLEDGES AND ACCEPTS THIS FIRST AMENDMENT TO LEASE, THIS 16th DAY OF 2019, 2019:

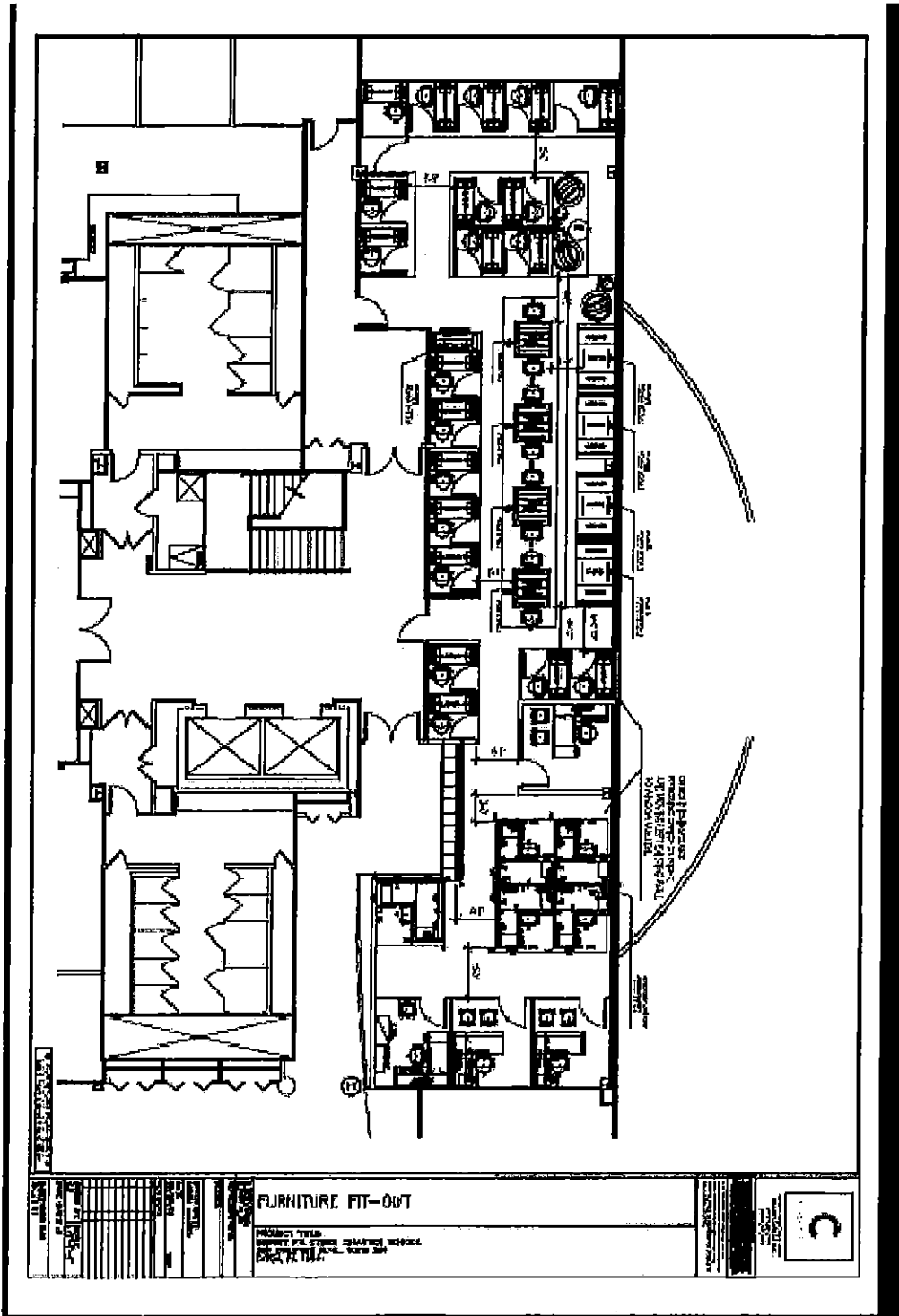
K12 VIRTUAL SCHOOLS LLC, GUARANTOR

BY: James Rhyne
Signed: ~~James Rhyne~~ July 16, 2019
Title: CFO

EXHIBIT "A"
PLAN

EXHIBIT "B"

LANDLORD'S EXPANSION WORK



Heritage Business Systems, Inc.

Lease Agreement

LESSEE	Full Legal Name Insight PA Cyber Charter School		Federal Tax ID 46-116314		Phone Number (877) 916-9149	
	Billing Address 350 Eagleview Blvd Suite 350, Exton, PA		City Exton		State Zip PA 19341	
	Send Email Invoice To:		Purchase Order Requisition Number			

EQUIPMENT	Make	Model Number	Serial Number	Quantity	Description (Attach Separate Schedule A if Necessary)
	Kyocera	TASKalfa 4002i		1	40 PPM A3 BW MFP
	Kyocera	TASKalfa 3552ci		1	35/35 PPM A3 Color MFP

PAYMENT INFORMATION	Number of Lease Payments	Lease Payment*	Plus Applicable Taxes		Term of Lease in Months	Payment Frequency	End of Lease Option:					
	60	\$254.00	Plus Applicable Taxes		60	<input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other	<input checked="" type="checkbox"/> FMV <input type="checkbox"/> 10% <input type="checkbox"/> \$1 <input type="checkbox"/> Other					
	Lease Payment <input type="checkbox"/> includes / <input checked="" type="checkbox"/> does NOT include maintenance/service/supplies [check one]					Security Deposit	(PLUS)	First Period Payment	(PLUS)	Other	(EQUALS)	Total Payment Enclosed
	*Lease payment may be adjusted for up front sales tax.					+		+			=	

1. **Lease:** You (the "Lessee") agree to lease from us (the "Lessor") the Equipment listed above and on any attached schedule (the "Lease"). You authorize us to adjust the Lease payments by up to 15% if the cost of the Equipment or taxes differs from the supplier's estimate. You agree to pay us a fee of \$75.00 to reimburse our expenses for preparing financing statements, other documentation costs and all ongoing administration costs during the term of this Lease. We may increase the Lease Payment on an annual basis, in an amount not to exceed fifteen percent (15%) of the Lease Payment in effect at the end of the prior annual period. Security deposits are non-interest bearing. If you are not in default, we will return the deposit to you when the Lease is terminated. If a payment is not made when due, you will pay us a late charge of 5% of the payment or \$10.00, whichever is greater. **YOU AGREE THAT NO ONE IS AUTHORIZED TO WAIVE OR CHANGE ANY LEASE TERM OR PROVISION.**

2. **Term:** This Lease is effective on the date that it is accepted and signed by us, and the term of this Lease begins on that date or any later date that we designate (the "Commencement Date") and continues thereafter for the number of months indicated above. Lease payments are due as invoiced by us. As you will have possession of the Equipment from the date of its delivery, if we accept and sign this Lease you will pay us interim rent for the period from the date the Equipment is delivered to you until the Commencement Date as reasonably calculated by us based on the Lease payment, the number of days in that period, and a month of 30 days. Your obligations are absolute, unconditional, and are not subject to cancellation, reduction, setoff or counterclaim.

3. **Title:** Unless you have a \$1.00 purchase option, we will have title to the Equipment. If you have a \$1.00 purchase option and/or the Lease is deemed to be a security agreement, you grant us a security interest in the Equipment and all proceeds thereof. You authorize us to file Uniform Commercial Code ("UCC") financing statements on the Equipment.

4. **Equipment Use, Maintenance and Warranties:** We are leasing the Equipment to you "AS-IS" AND MAKE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE. We transfer to you any manufacturer warranties. You are required at your cost to keep the Equipment in good working condition and to pay for all supplies and repairs. The Lease Payments set forth above do not include the cost of maintenance, service, and/or supplies ("Service"), unless indicated in the above "Payment Information" box. Notwithstanding anything to the contrary, however, you agree that we are not responsible for providing such Service for the Equipment and you will make all claims related to Service to the Service provider ("Provider"). No Provider may alter the terms of this Lease or make any promises or arrangements that alter our rights or your obligations under this Lease. You agree that you are expressly assuming any risks arising from such Provider's inability to deliver such Service, under any circumstance, including, without limitation, such Provider's financial condition or its inability to repair or service the Equipment. You agree that any claims related to Service will not impact your obligation to pay all Lease payments when due.

5. **Assignment:** You agree not to transfer, sell, sublease, assign, pledge or encumber either the Equipment or any rights under this Lease without our prior written consent. You agree that we may sell, assign, or transfer the Lease and the new owner will have the same rights and benefits we now have and will not have to perform any of our obligations and the rights of the new owner will not be subject to any claims, defenses, or setoffs that you may have against us or any supplier.

6. **Risk of Loss and Insurance:** You are responsible for risks of loss or damage to the Equipment and if any loss occurs you are required to satisfy all of your Lease obligations. You will keep the Equipment insured against all risks of loss or damage for an amount equal to its replacement cost. You will list us as the sole loss payee for the insurance and give us written proof of the insurance. If you do not provide such insurance, you agree that we have the right, but not the obligation, to obtain insurance against theft and physical damage, and add an insurance fee to the amount due from you, on which we may make a profit. We are not responsible for any losses or injuries caused by the Equipment and you will reimburse us and defend us against any such claims. This indemnity will continue after the termination of this Lease. You will obtain and maintain comprehensive public liability insurance naming us as an additional insured with coverages and amounts acceptable to us.

7. **Taxes:** You agree to pay when due, either directly or as a reimbursement to us, all taxes (including, without limit, sales, use, and personal property) and charges in connection with ownership, lease and use of the Equipment. We may charge you a processing fee for adminis-

tering property tax filings. You will indemnify us on an after-tax basis against the loss or unavailability of any tax benefits anticipated at the Commencement Date arising out of your acts or omissions. This indemnity will continue even after the termination of this Lease.

8. **Default and Remedies:** You are in default on this Lease if: a) you fail to pay a Lease payment or any other amount when due; or b) you breach any other obligation under the Lease or any other Lease with us. If you are in default on the Lease we may: (i) declare the entire balance of unpaid Lease payments for the full Lease term immediately due and payable to us; (ii) sue you for and receive the total amount due on the Lease plus the Equipment's anticipated end of Lease fair market value or fixed price purchase option (the "Residual") with future lease payments and the Residual discounted to the date of default at 1% per annum, plus reasonable collection and legal costs; (iii) charge you interest on all monies due at the rate of 18% per year or the highest rate permitted by law from the date of default; (iv) charge you a return-check or non-sufficient funds charge ("NSF Charge") of \$25.00 for a check that is returned; and (v) require that you immediately return the Equipment to us or we may peaceably repossess it. Any return or repossession will not be considered a termination or cancellation of the Lease. If the Equipment is returned or repossessed we will sell or re-rent the Equipment at terms we determine, at one or more public or private sales, with or without notice to you, and apply the net proceeds (after deducting any related expenses) to your obligations. You remain liable for any deficiency with any excess being retained by us. You agree that if notice of sale is required by law to be given, 10 days notice will constitute reasonable notice. You are also required to pay (i) all expenses incurred by us in connection with enforcement of any remedies, including all expenses of repossessing, storing, shipping, repairing, and selling the Equipment, and (ii) reasonable attorney's fees.

9. **End of Lease, Return, Purchase Option, and Renewal:** You will give us at least 60 days but not more than 120 days written notice (to our address below) before the expiration of the initial lease term (or any renewal term) of your intention to purchase or return the Equipment. With proper notice you may: a) purchase all the Equipment as indicated above under "End of Lease Option" (fair market value purchase option amounts will be determined by us based on the Equipment's in place value); or b) return all the Equipment in good working condition at your cost in a timely manner, and to a location we designate. If you fail to notify us, or if you do not (i) purchase or (ii) return the Equipment as provided herein, this Lease will automatically renew at the same payment amount for consecutive 12 month periods. If the Equipment is returned to us, you shall remove all confidential information from the Equipment prior to return. If any Software license ("License") included hereunder passes title to you, such title shall automatically vest and remain in us. If such vesting requires a written conveyance, you hereby convey to us any title you have or hereafter acquire in the Software and relinquish any subsequent title in the Software. If licensor's consent is required, you shall assist us in obtaining consent.

10. **Miscellaneous:** You agree that the Lease is a Finance Lease as defined in Article 2A of the Uniform Commercial Code ("UCC"). You acknowledge that we have given you the Equipment supplier's name. We hereby notify you that you may have rights under the supplier's contract and may contact the supplier for a description of these rights. You agree that we are authorized, without notice to you, to supply missing information or correct obvious errors in the Lease. This Lease was made in the state of Lessor or its assignee's principal place of business, is to be performed in that state and shall be governed and construed in accordance with its laws. You consent to jurisdiction, personal or otherwise, in any state or federal court in state of Lessor or its assignee's principal place of business and waive a trial by jury. You agree (i) to waive any and all rights and remedies granted to you under UCC Section 2A-508 through 2A-522, (ii) that the Equipment will only be used for business purposes and not for personal, family, or household use, and will not be moved from the above location without our consent, and (iii) this Lease may be executed in counterparts and any facsimile, photographic or other electronic transmission and/or electronic signing of this Lease by you when manually countersigned by us or attached to our original signature counterpart and/or in our possession shall constitute the sole original chattel paper as defined in the UCC for all purposes and will be admissible as legal evidence thereof. At our option, we may require a manual signature. We may inspect the Equipment during the Lease term. We shall not be liable to you for indirect, special, or consequential damages. No failure to act shall be deemed a waiver of any rights hereunder.

LESSEE SIGNATURE	You agree that this is a non-cancelable lease. The Equipment is: <input checked="" type="checkbox"/> NEW <input type="checkbox"/> USED	
	Signature <i>Beth Jones</i>	Date <i>03/04/2019</i>
	Title <i>CFO</i>	Print Name <i>Beth Jones</i>
	Legal Name of Corporation Insight PA Cyber Charter School	

LESSOR	Heritage Business Systems, Inc. Lease Processing Center, 1263 Glen Ave., Moorestown, NJ 08057 Phone: (856) 722-7001 - FAX: (856) 722-1161	
	Commencement Date	Lease Number
	Accepted By:	

ACCEPTANCE	The Equipment has been received, put in use, is in good working order and is satisfactory and acceptable.			
	Signature	Date	Print Name	Title

GUARANTY	I unconditionally guaranty prompt payment of all the Lessee's obligations under the Lease. The Lessor is not required to proceed against the Lessee or the Equipment or enforce other remedies before proceeding against me. I waive notice of acceptance and all other notices or demands of any kind to which I may be entitled. I consent to any extensions or modification granted to the Lessee and the release and/or compromise of any obligations of the Lessee or any other guarantors without releasing me from my obligations. This is a continuing guaranty and will remain in effect in the event of my death and may be enforced by or for the benefit of any assignee or successor of the Lessor. This guaranty is governed by and constituted in accordance with the laws state of Lessor or its assignee's principal place of business and I consent to non-exclusive jurisdiction of any state or federal court in that state and waive trial by jury.		
	Signature	Print Name	Date

17HER034v1

H Heritage Business Systems, Inc.
www.heritagebusiness.com

Corporate 555 City Line Avenue
1263 Glen Avenue Suite 900
Moorestown, NJ 08057 Bala Cynwyd, PA 19004
Phone: 856-722-7001 Phone: (610) 617-9901

CUSTOMER
PHONE# 877 916-9149

CUSTOMER
FAX#

DATE ORDERED
02/21/2019

ORDER ID#
30328

Sold To Insight PA Cyber Charter School
350 Eagleview Blvd Suite 350, Exton, PA 19341
Exton, PA 19341

Ship To Insight PA Cyber Charter School
350 Eagleview Blvd Suite 350, Exton, PA 19341
Exton, PA 19341

(If Blank, Same as Sold To)

TERMS: SUPPLIES NET 15 DAYS
EQUIPMENT 25% WITH ORDER - BALANCE ON INSTALLATION

CUSTOMER ACCOUNT NUMBER		SALESMAN NUMBER Anthony Antonio		CUSTOMER ORDER NUMBER		SEND VIA Bestway		DATE WANTED ASAP	
QUANTITY ORDERED	QUANTITY SHIPPED	B/O	DESCRIPTION			UNIT PRICE	TOTAL AMOUNT		
1			TASKalfa 4002i-40 PPM A3 BW MFP						
1			PF-7110-Dual 1500 Sheet Paper Trays						
1			DP-7110-270 Sheet Dual Scan Document Processor						
1			DF-7120-1000 sheets Finisher						
1			TK-6327(Approx. 35k Yield @ 6% Coverage)-Black Toner Container (12 Containers/Case)						
1			TASKalfa 3552ci-35/35 PPM A3 Color MFP						
1			PH-7A-2/3 Hole Punch Unit for DF-7120/DF-791						
1			PF-7110-Dual 1500 Sheet Paper Trays						
Leasing Company		Payment Frequency		Lease Term		Lease Payment			
DLL		Monthly		60		\$254.00 (plus applicable taxes)			

NO TERMS OR CONDITIONS, EXPRESS OR IMPLIED, ARE AUTHORIZED UNLESS THEY APPEAR ON "ORIGINAL" OF THIS ORDER.
 • ALL INVOICES PAID AFTER DUE DATE WILL BE ASSESSED THE LATE PAYMENT SERVICE CHARGE OF 18% PER ANNUM OR THE MAXIMUM ALLOWED BY APPLICABLE LAW, WHICHEVER IS LOWER.
 • THIS ORDER IS SUBJECT TO THE TERMS AND CONDITIONS APPEARING HEREON AND THE REVERSE SIDE HEREOF, AND BUYER AGREES TO BE BOUND THEREBY, NO MODIFICATIONS OR ADDITIONS THERETO SHALL BE BINDING UPON SELLER UNLESS EXPRESSLY CONSENTED TO IN WRITING BY AN OFFICER OF THE CORPORATION. CREDIT WILL NOT BE ISSUED ON RETURNED SUPPLIES FOR ANY OPENED PACKAGES.

GROSS AMOUNT
FREIGHT AMOUNT
SALES TAX
TOTAL THIS ORDER

SPECIAL INSTRUCTIONS:

FREIGHT CHARGES
ALL SHIPMENTS, INCLUDING SUPPLIES, MOORESTOWN, NJ
EQUIPMENT DELIVERY & INSTALLATION
 CONSOLE MODELS - \$250.00
 DESK TOP:
 250 LBS. & OVER - \$150.00
 BELOW 250 LBS. - \$100.00

NEW ACCOUNT INFORMATION	SALESMEN'S ORDERS ARE SUBJECT TO FINAL ACCEPTANCE BY HERITAGE BUSINESS SYSTEMS, INC.
COMPANY BANK _____ ACCT.# _____	COMPANY NAME: ^{PA} <u>Insight Cyber Charter School</u>
TRADE _____ PHONE # _____	AUTHORIZED SIGNATURE <u>[Signature]</u> TITLE <u>CFO 3/4/2019</u>
TRADE _____ PHONE # _____	RECEIVED BY _____ DATE _____
OWNER/OFFICER _____	SALESMAN'S SIGNATURE _____ DATE _____
SOCIAL SECURITY # _____	



1263 Glen Avenue
 Moorestown, NJ 08057
 (856) 722-7001
 (800) 422-7411
 Fax: (865) 722-1161

555 City Line Avenue
 Suite 900
 Bala Cynwyd, PA 19004

3525 Quakerbridge Road
 Suite 910
 Hamilton, NJ 08619

COMPREHENSIVE CUSTOMER SUPPORT AGREEMENT

CUSTOMER: Insight Cyber Charter School ACCT #: _____
 ADDRESS: 350 Eagleview Blvd Suite 350, Exton, PA 19341 DATE: 02/10/2019
 CITY/ZIP: Exton, PA 19341 PHONE: 877 916-9149
 FAX: _____

CONTACT: _____ METER COLLECTION _____
 EMAIL ADDRESS: _____

MAKE: Kyocera MODEL: TASKalfa 4002i/TASKalfa 3552ci SERIAL # _____

ID #: _____ TERM: 60 START DATE: _____ END DATE: _____

FM AUDIT: Server Permanent Workstation Location/IP Address: _____

CONTRACT TYPE: All Inclusive MONTHLY QUARTERLY

BLOCK CONTRACT: BASE & OVERAGE BLACK/WHITE COPIES/PRINTS Start Meter: _____
 BASE & OVERAGE COLOR COPIES/PRINTS: Start Meter: _____

Copies per Cycle: _____ Minimum Base Charge: _____ Minimum Base Charge: _____
 Months per Cycle: _____ Copies Included: _____ Copies Included: _____
 Cost per Cycle: _____ Overage cost per copy: .006 Overage cost per copy: .045

Freight (one time fee): _____
 PLUS APPLICABLE TAXES _____
 CONTRACT INSPECTION REQUIRED? YES NO

HERITAG EBUSINESS SYSTEMS, INC. MAY CANCEL THIS AGREEMENT BY GIVING THIRTY DAYS NOTICE.
 EXCLUDES ALL NETWORK OR COMPUTER SUPPORT THAT MAY BE NEEDED OUTSIDE OF THE ORIGINAL INSTALLATION.
 CONTRACT RATE MAY INCREASE ON AN ANNUAL BASIS.

Customer Signature: X *Beth J* Date: X 3/4/2019
 HBS Officer Signature: X _____ Date: X _____

 MANAGED PRINT SERVICES: YES NO
 EQUIPMENT: SEE ATTACHED SCHEDULE A CPP RATE:: _____
 ESTIMATED # OF PRINTERS: _____ MINIMUM MONTHLY BASE CHARGE: _____
 PRINT INCLUDED: _____

Managed Print: Shall cover all parts, labor and supplies.

Heritage Business Systems, Inc. may cancel this agreement by giving thirty days notice.
 Excludes all network or computer support that may be needed outside of the original installation.
 Contract rate may increase on an annual basis.

Customer Signature: X _____ Date: X _____
 Service Manager Signature: X _____ Date: X _____

SUBJECT TO TERMS AND CONDITIONS APPEARING HEREON AND THE REVERSE SIDE HEREOF, AND BUYER AGREES TO BE BOUND THEREBY.
 Revision: 1:5 9-11-12

ALL INCLUSIVE STATEMENT

Under an All-Inclusive Agreement Heritage Business Systems, Inc. (hereinafter "HBS, Inc."), will furnish all service, parts, labor, drums, toner and developer to produce a published guarantee yield. Copies are based on an 8.5" x 11" sheet of bond paper; in addition on "wide format" equipment copies are based on "count" (linear foot). Excludes paper and staples and any network support.

MAINTENANCE PLUS

Digital Copiers: Shall cover all service, parts, labor and toner, excluding drums, developer, paper and staples.
Color Copiers: Shall cover all service, parts, labor and toner, excluding drums, developer, paper and staples.
Facsimile: Shall cover all service, parts, labor and (1) initial toner cartridge.

MAINTENANCE ONLY STATEMENT

Digital Copiers: Shall cover all service, parts and labor, excluding toner, developer, imaging units, maintenance kits, staples, disposal tanks and paper.
Color Copiers: Shall cover all service, parts and labor, excluding toner, developer, fuser oil, staples, disposal tanks and paper.
***Color Printers:** Shall cover all service, parts and labor, excluding toner, charger units, imaging units, disposal tanks, fuser oil, fuser cleaner, fusing unit and maintenance kit/development units
***Black/White Printers:** Shall cover all service, parts and labor, excluding toner, drum kit, developer kit, maintenance kit, fuser unit, process unit and scanner unit.
Facsimile: Shall cover all service, parts and labor, excluding toner and imaging units.
Duplicators: Shall cover all service, parts and labor, excluding ink and masters
Shredder: Shall cover all service, parts and labor, excluding cutting assembly and/or blades
Color Ink Jet Wide Format: Shall cover all parts, labor and travel excludes print heads, paper and ink.

OPTIONAL MAINTENANCE

Excludes maintenance required after the end-user installs software, software updates or any changes to the operating systems are made. Any labor related to network, related problems, not directly involved in the replacement or repair of items in this Agreement.

GENERAL TERMS AND CONDITIONS

1. This Annual Maintenance Program shall not apply to repairs made necessary by accident, misuse, abuse, neglect, theft, vandalism, electrical power failure, water, acts of God, or other casualty or to repairs made necessary by service performed by personnel other than HBS Inc.
2. The equipment shall be in good mechanical condition on the date of commencement of this Agreement, as determined by HBS Inc. and its service technicians.
3. This Agreement is not assignable and is automatically cancelled with respect to the particular machines, should the equipment it covers be sold to a third party.
4. In the event the equipment is moved out of HBS Inc.'s normal service area, HBS Inc. shall have the right to terminate this Agreement and cease all future service on the equipment.
5. Excluded from this Agreement are modifications to the equipment and overhauls.
6. Service hours – Monday through Friday, 8:30 am – 5:00 pm. HBS Inc. will be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.
7. Drums replaced as a result of normal use will be replaced at no charge. The following conditions would be the exception. Replacement of abused drums will be charged at full price. Examples of how a drum can be abused are listed below:
 - A. Touching the drum with fingers/ foreign objects or use of supplies other than those recommended by the manufacturer.
 - B. Allowing machine to be used in an environment contrary to manufacturer's recommendations.
8. This Agreement does not cover:
 - A. Service necessitated by exceeding manufacturers recommended volume limitations, the malfunction of Non-Original Manufacturer's Equipment, parts, supplies, attachments, or supplies not authorized by HBS Inc.
 - B. Repairs of cleaning necessitated by the improper installation of toner, developer or foreign agents
 - C. Exterior and add-on copy counting or monitoring devices (i.e. Hecon, Copyguard system).
 - D. Expenses incurred for supplies consumed in the course of service performed, damaged or misused by the customer are non-recoverable and replenishment of such supplies is the sole responsibility of the customer.
9. Customer agrees to:
 - A. Provide suitable electrical service and maintain proper environmental conditions
 - B. Pay for special servicing possibly required to prepare the equipment for movement or to reinstall and adjust after a movement
 - C. Provide HBS Inc. with meter readings as needed and to accept estimated meter readings based on service history.
 - D. HBS, Inc. reserves the right to install a meter collection agent on the server and or workstation at the customers location
10. **Network Support:** I hereby authorize HBS, Inc. and its representatives to operate the computer systems for purposes of testing, troubleshooting and inspection at my risk. They may install the necessary materials (both hardware and software) into the described equipment. HBS Inc. shall not be held liable for any expenses or damages incurred during the installation or use of the above hardware or software by HBS or yourself.
11. **Installation Agreement and Disclosure:** I hereby authorize HBS, Inc. and their representatives to operate the computer systems for purposes of testing, troubleshooting and inspection at my risk. They may install the necessary materials (both hardware and software) into the described equipment. HBS, Inc. shall not be held liable for any expenses of damages incurred during the installation or use of the above hardware or software by HBS, yourself or any third party. I agree not to hold HBS Inc. responsible for any loss of damage due to fire, flood, vandalism, theft, accident or by any and all other cause(s). I acknowledge that an integral part of this installation procedure and normal operation of a computer system is the performance of regular back-ups. HBS Inc. will not perform a back-up of my computer systems, and I hereby release HBS Inc. from any liability regarding lost data on any fixed or removable drives.
12. **Software Agreement:** By using the provided software and associated materials, the user agrees that they have read, understood and will comply with the following Agreement. This software and any associated material is provided "as-is" and HBS, Inc. makes no representations or warranties, including but not limited to the use, ownership, portability or distribution of the provided software. HBS, Inc. shall not be liable for any damages or expenses incurred, with respect to any claims by the user or any third party, arising from the installation, use or the inability to use the provided software and associated material. Title to the copyright of the software and associated materials shall at all times remain with the creator. Any use, distribution, copying, or modifying of the software or associated materials shall be subject to the terms of the creator.
13. **Recommended Computer Requirements:** I understand that the digital equipment may not function properly on computer systems or networks that have not met specific minimum requirements. Any expenses incurred while satisfying the network and computer systems hardware or software requirements by the user, HBS, Inc. or any third party shall be the sole responsibility of the purchaser. No refunds of installation fees will be given if all minimum requirements are not satisfied.
14. This Agreement contains the entire understanding, Agreement and contract between HBS, Inc. and the Customer and each agrees that no representation, warranty or covenant was made by or on behalf of the other that is not contained in the Agreement, and that in entering into this Agreement neither party relied upon any representation, warranty or covenant not herein contained.
15. Handwritten and/or typewritten provisions inserted into this Agreement initialed by both parties and expressly approved in writing by a HBS Authorized Officer shall control over the typewritten provisions in conflict therewith.
16. This Agreement shall be governed by, and interpreted and enforced in accordance with the laws of the State of New Jersey.
17. If any legal action or other proceeding or action is brought forth for the enforcement of this Agreement, or because of an alleged dispute, breach, default, or misrepresentation in connection with any provision of the Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorney's fees, court costs, and all other expenses, even if not taxable court costs (including without limitation, all such fees, costs and expenses incident of arbitration, appellate, bankruptcy, and post-judgment proceedings), incurred in that action or proceeding or any appeal, in addition to any other relief to which the party or parties may be entitled. Furthermore, the Customer agrees to pay all costs of collection including reasonable attorney's fees whether suit be brought or not, incurred by HBS, Inc. in collecting any past due balances or recovering any equipment.
18. Customer's exclusive remedy and HBS, Inc.'s entire liability, in contract, tort, or otherwise, shall be to make all necessary repairs to the equipment and to keep the equipment in good operating condition. In no event shall HBS, Inc. be liable for any indirect, special or consequential damages arising from the Agreement or use of the Equipment or any services provided under this Agreement.
19. In the event the Agreement is terminated prior to the end of the Agreement term, either by the Customer or by HBS, Inc. as a result of a Customer default, the Customer shall nonetheless be obligated to pay HBS, Inc. all amounts due for the balance of the Agreement term. These amounts shall be accelerated and become due and payable immediately upon such termination.

- Unless covered under an MPS Agreement. In such case all parts, labor and supplies.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

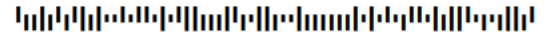
REMITTANCE SECTION

Invoice Number: 63122885
 Due Date: 05/01/2019
 Due This Period: \$269.24

Amount Enclosed: \$ _____

Please make check payable to:

DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602



INSIGHT PA CYBER CHARTER SCHOOL
 ATTN: AP
 350 EAGLEVIEW BLVD STE 350
 EXTON PA 19341-1198

2100000631228850000269241

Detach here. Please include the top payment coupon with your payment. Please allow 5-7 days for U.S. Postal Service delivery.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

Contract Number: 500-50000488
 Invoice Number: 63122885
 Account Number: 1293803
 Site Number: 4522182
 Invoice Date: 04/06/2019
 Period of Performance: 04/01/2019-04/30/2019
 Due This Period: \$269.24

WWW.LESSEEDIRECT.COM

IMPORTANT MESSAGES

*Please review your equipment location(s) for tax purposes.

Visit WWW.LESSEEDIRECT.COM

Did you know you can...

- ✓ View copies of your contract and open invoices
- ✓ Enroll in paperless invoicing
- ✓ Make a payment
- ✓ Set up automated/recurring payments

See Reverse For Important Information

INVOICE DETAILS

Description	Payment Amount	Tax	Total Amount	Applied Amount	Remaining Amount Due
PAYMENT	\$254.00	\$15.24	\$269.24	\$0.00	\$269.24
Billed this Invoice	\$254.00	\$15.24	\$269.24	\$0.00	\$269.24

(Please see the following pages for details.)

ASSET DETAILS

Contract Number	Serial Number	Purchase Order	Make / Model	Asset Number	Install Date	Cost Center	Department	Payment Amount	Tax	Total Amount
500-50000488	W378914437		Kyocera / TASKalfa 4002i	50000488_1				\$110.57	\$6.63	\$117.20
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 19341-1198 United States										
500-50000488	RFE9100358		Kyocera / TASKalfa 3553ci	50000488_2				\$143.43	\$8.61	\$152.04
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 19341-1198 United States										
									Asset Amount Total:	\$269.24

Contact Us



WWW.LESSEEDIRECT.COM

- ✓ View contract and invoice copies
- ✓ View open balances and a Pay History of your contract
- ✓ Enroll in Paperless
- ✓ Update your insurance
- ✓ Update your Billing or Asset Address
- ✓ Enroll in Direct Debit



Correspondence Address

DE LAGE LANDEN FINANCIAL SERVICES, INC.
1111 OLD EAGLE SCHOOL RD
WAYNE, PA 19087-1453

*Please provide your contract number



Customer Service

800-736-0220

Important Reminder

Enclose remittance slip with your check and send it to the address on the reverse side to ensure accurate and timely processing of your payment. **Please remit payments at least 5 days prior to due date. Please record your Invoice number on the check.**

Explanation of Charges

It is important to us that you understand the charges on your invoice. Please refer to this guide for assistance.

1. **DOCUMENTATION/ORIGINATION FEE** – A one-time fee assessed on new transactions to cover our expenses for preparing financing statements and other documentation costs.
2. **INTERIM PAYMENT** – A charge to account for the partial month, prior to the first full billing cycle, calculated per the terms and conditions in the contract.
3. **INSURANCE CHARGE** – A charge due each billing period as the result of the equipment being insured by the lessor against theft or damage.
4. **PAYMENT** – Amount due each billing period in accordance with the terms of the contract.
5. **LATE FEE** – Assessed when a payment is not received by its due date, as provided by the contract.
6. **FINANCE CHARGE** – Assessed when a payment is not received and is over thirty (30) days past its due date.
7. **PROPERTY TAX** – The lessor, as the owner of the equipment, is assessed and pays property tax to the appropriate taxing authority on an annual basis. Per the contract, the Lessee has agreed to reimburse the Lessor for all property taxes paid on their behalf plus reasonable administrative costs. For questions about taxes, call the Customer Service number above.
8. **RETURNED CHECK FEE** – Assessed each time a check is returned for any reason.
9. **CUSTOMER SERVICE FEE** – Assessed when a request for an amortization schedule, an invoice copy, a pay history or additional contract copy is requested.
10. **ACCOUNT SUMMARY** – Overview of prior billed invoices for which a partial or no payment was received at the time the current invoice was printed.
11. **TAX OR LESSOR SURCHARGE** – Taxes due in accordance with the tax laws of the state(s) where the equipment is located. For tax related questions, call the Customer Service number above.

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
De Lage Landen Financial Services, Inc

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

Individual/sole proprietor or single-member LLC

C Corporation

S Corporation

Partnership

Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶ _____

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
1111 Old Eagle School Road

6 City, state, and ZIP code
Wayne, PA 19087

7 List account number(s) here (optional)

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

OR

Employer identification number

3	8	-	1	9	0	4	5	0	0
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here

Signature of U.S. person ▶

Date ▶

1/2/19

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

REMITTANCE SECTION

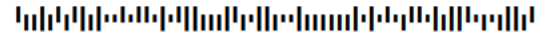
Invoice Number: 63122885
 Due Date: 05/01/2019
 Due This Period: \$269.24

Amount Enclosed: \$ _____

INSIGHT PA CYBER CHARTER SCHOOL
 ATTN: AP
 350 EAGLEVIEW BLVD STE 350
 EXTON PA 19341-1198

Please make check payable to:

DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602



2100000631228850000269241

Detach here. Please include the top payment coupon with your payment. Please allow 5-7 days for U.S. Postal Service delivery.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

Contract Number: 500-50000488
 Invoice Number: 63122885
 Account Number: 1293803
 Site Number: 4522182
 Invoice Date: 04/06/2019
 Period of Performance: 04/01/2019-04/30/2019
 Due This Period: \$269.24

WWW.LESSEEDIRECT.COM

IMPORTANT MESSAGES

*Please review your equipment location(s) for tax purposes.

Visit WWW.LESSEEDIRECT.COM

Did you know you can...

- ✓ View copies of your contract and open invoices
- ✓ Enroll in paperless invoicing
- ✓ Make a payment
- ✓ Set up automated/recurring payments

See Reverse For Important Information

INVOICE DETAILS

Description	Payment Amount	Tax	Total Amount	Applied Amount	Remaining Amount Due
PAYMENT	\$254.00	\$15.24	\$269.24	\$0.00	\$269.24
Billed this Invoice	\$254.00	\$15.24	\$269.24	\$0.00	\$269.24

(Please see the following pages for details.)

ASSET DETAILS

Contract Number	Serial Number	Purchase Order	Make / Model	Asset Number	Install Date	Cost Center	Department	Payment Amount	Tax	Total Amount
500-50000488	W378914437		Kyocera / TASKalfa 4002i	50000488_1				\$110.57	\$6.63	\$117.20
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 19341-1198 United States										
500-50000488	RFE9100358		Kyocera / TASKalfa 3553ci	50000488_2				\$143.43	\$8.61	\$152.04
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 19341-1198 United States										
									Asset Amount Total:	\$269.24

Contact Us



WWW.LESSEEDIRECT.COM

- ✓ View contract and invoice copies
- ✓ View open balances and a Pay History of your contract
- ✓ Enroll in Paperless

- ✓ Update your insurance
- ✓ Update your Billing or Asset Address
- ✓ Enroll in Direct Debit



Correspondence Address

DE LAGE LANDEN FINANCIAL SERVICES, INC.
1111 OLD EAGLE SCHOOL RD
WAYNE, PA 19087-1453

*Please provide your contract number



Customer Service

800-736-0220

Important Reminder

Enclose remittance slip with your check and send it to the address on the reverse side to ensure accurate and timely processing of your payment. **Please remit payments at least 5 days prior to due date. Please record your Invoice number on the check.**

Explanation of Charges

It is important to us that you understand the charges on your invoice. Please refer to this guide for assistance.

1. **DOCUMENTATION/ORIGINATION FEE** – A one-time fee assessed on new transactions to cover our expenses for preparing financing statements and other documentation costs.
2. **INTERIM PAYMENT** – A charge to account for the partial month, prior to the first full billing cycle, calculated per the terms and conditions in the contract.
3. **INSURANCE CHARGE** – A charge due each billing period as the result of the equipment being insured by the lessor against theft or damage.
4. **PAYMENT** – Amount due each billing period in accordance with the terms of the contract.
5. **LATE FEE** – Assessed when a payment is not received by its due date, as provided by the contract.
6. **FINANCE CHARGE** – Assessed when a payment is not received and is over thirty (30) days past its due date.
7. **PROPERTY TAX** – The lessor, as the owner of the equipment, is assessed and pays property tax to the appropriate taxing authority on an annual basis. Per the contract, the Lessee has agreed to reimburse the Lessor for all property taxes paid on their behalf plus reasonable administrative costs. For questions about taxes, call the Customer Service number above.
8. **RETURNED CHECK FEE** – Assessed each time a check is returned for any reason.
9. **CUSTOMER SERVICE FEE** – Assessed when a request for an amortization schedule, an invoice copy, a pay history or additional contract copy is requested.
10. **ACCOUNT SUMMARY** – Overview of prior billed invoices for which a partial or no payment was received at the time the current invoice was printed.
11. **TAX OR LESSOR SURCHARGE** – Taxes due in accordance with the tax laws of the state(s) where the equipment is located. For tax related questions, call the Customer Service number above.

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
De Lage Landen Financial Services, Inc

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

Individual/sole proprietor or single-member LLC

C Corporation

S Corporation

Partnership

Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶ _____

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
1111 Old Eagle School Road

6 City, state, and ZIP code
Wayne, PA 19087

7 List account number(s) here (optional)

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

OR

Employer identification number

3	8	-	1	9	0	4	5	0	0
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here

Signature of U.S. person ▶

Date ▶

1/2/19

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
PO BOX 41602
PHILADELPHIA, PA 19101-1602

REMITTANCE SECTION

Invoice Number: 63495162
Due Date: 06/01/2019
Due This Period: \$254.00

Amount Enclosed: \$ _____

Please make check payable to:

DE LAGE LANDEN FINANCIAL SERVICES, INC.
PO BOX 41602
PHILADELPHIA, PA 19101-1602



INSIGHT PA CYBER CHARTER SCHOOL
ATTN: AP
350 EAGLEVIEW BLVD STE 350
EXTON PA 19341-1198

2100000634951620000254005

Detach here. Please include the top payment coupon with your payment. Please allow 5-7 days for U.S. Postal Service delivery.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
PO BOX 41602
PHILADELPHIA, PA 19101-1602

WWW.LESSEEDIRECT.COM

Contract Number: 500-50000488
Invoice Number: 63495162
Account Number: 1293803
Site Number: 4522182
Invoice Date: 05/11/2019
Period of Performance: 05/01/2019-05/31/2019
Due This Period: \$254.00

IMPORTANT MESSAGES

*Please review your equipment location(s) for tax purposes.

Visit WWW.LESSEEDIRECT.COM

- Did you know you can...
- ✓ View copies of your contract and open invoices
 - ✓ Enroll in paperless invoicing
 - ✓ Make a payment
 - ✓ Set up automated/recurring payments

See Reverse For Important Information

INVOICE DETAILS

Description	Payment Amount	Tax	Total Amount	Applied Amount	Remaining Amount Due
PAYMENT	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00
Billed this Invoice	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00

(Please see the following pages for details.)

ASSET DETAILS

Contract Number	Serial Number	Purchase Order	Make / Model	Asset Number	Install Date	Cost Center	Department	Payment Amount	Tax	Total Amount
500-50000488	W378914437		Kyocera / TASKalfa 4002i	50000488_1				\$110.57	\$0.00	\$110.57
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
500-50000488	RFE9100358		Kyocera / TASKalfa 3553ci	50000488_2				\$143.43	\$0.00	\$143.43
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
									Asset Amount Total:	\$254.00

Contact Us



WWW.LESSEEDIRECT.COM

- ✓ View contract and invoice copies
- ✓ View open balances and a Pay History of your contract
- ✓ Enroll in Paperless
- ✓ Update your insurance
- ✓ Update your Billing or Asset Address
- ✓ Enroll in Direct Debit



Correspondence Address

DE LAGE LANDEN FINANCIAL SERVICES, INC.
1111 OLD EAGLE SCHOOL RD
WAYNE, PA 19087-1453

*Please provide your contract number



Customer Service

800-736-0220

Important Reminder

Enclose remittance slip with your check and send it to the address on the reverse side to ensure accurate and timely processing of your payment. **Please remit payments at least 5 days prior to due date. Please record your Invoice number on the check.**

Explanation of Charges

It is important to us that you understand the charges on your invoice. Please refer to this guide for assistance.

1. **DOCUMENTATION/ORIGINATION FEE** – A one-time fee assessed on new transactions to cover our expenses for preparing financing statements and other documentation costs.
2. **INTERIM PAYMENT** – A charge to account for the partial month, prior to the first full billing cycle, calculated per the terms and conditions in the contract.
3. **INSURANCE CHARGE** – A charge due each billing period as the result of the equipment being insured by the lessor against theft or damage.
4. **PAYMENT** – Amount due each billing period in accordance with the terms of the contract.
5. **LATE FEE** – Assessed when a payment is not received by its due date, as provided by the contract.
6. **FINANCE CHARGE** – Assessed when a payment is not received and is over thirty (30) days past its due date.
7. **PROPERTY TAX** – The lessor, as the owner of the equipment, is assessed and pays property tax to the appropriate taxing authority on an annual basis. Per the contract, the Lessee has agreed to reimburse the Lessor for all property taxes paid on their behalf plus reasonable administrative costs. For questions about taxes, call the Customer Service number above.
8. **RETURNED CHECK FEE** – Assessed each time a check is returned for any reason.
9. **CUSTOMER SERVICE FEE** – Assessed when a request for an amortization schedule, an invoice copy, a pay history or additional contract copy is requested.
10. **ACCOUNT SUMMARY** – Overview of prior billed invoices for which a partial or no payment was received at the time the current invoice was printed.
11. **TAX OR LESSOR SURCHARGE** – Taxes due in accordance with the tax laws of the state(s) where the equipment is located. For tax related questions, call the Customer Service number above.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

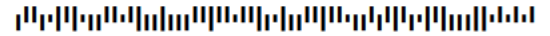
REMITTANCE SECTION

Invoice Number: 63495162
 Due Date: 06/01/2019
 Due This Period: \$254.00

Amount Enclosed: \$ _____

Please make check payable to:

DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602



INSIGHT PA CYBER CHARTER SCHOOL
 ATTN: AP
 350 EAGLEVIEW BLVD STE 350
 EXTON PA 19341-1198

2100000634951620000254005

Detach here. Please include the top payment coupon with your payment. Please allow 5-7 days for U.S. Postal Service delivery.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

WWW.LESSEEDIRECT.COM

Contract Number: 500-50000488
 Invoice Number: 63495162
 Account Number: 1293803
 Site Number: 4522182
 Invoice Date: 05/11/2019
 Period of Performance: 05/01/2019-05/31/2019
 Due This Period: \$254.00

IMPORTANT MESSAGES

*Please review your equipment location(s) for tax purposes.

Visit WWW.LESSEEDIRECT.COM

- Did you know you can...
- ✓ View copies of your contract and open invoices
 - ✓ Enroll in paperless invoicing
 - ✓ Make a payment
 - ✓ Set up automated/recurring payments

See Reverse For Important Information

INVOICE DETAILS

Description	Payment Amount	Tax	Total Amount	Applied Amount	Remaining Amount Due
PAYMENT	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00
Billed this Invoice	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00

(Please see the following pages for details.)

ASSET DETAILS

Contract Number	Serial Number	Purchase Order	Make / Model	Asset Number	Install Date	Cost Center	Department	Payment Amount	Tax	Total Amount
500-50000488	W378914437		Kyocera / TASKalfa 4002i	50000488_1				\$110.57	\$0.00	\$110.57
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
500-50000488	RFE9100358		Kyocera / TASKalfa 3553ci	50000488_2				\$143.43	\$0.00	\$143.43
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
									Asset Amount Total:	\$254.00

Contact Us



WWW.LESSEEDIRECT.COM

- ✓ View contract and invoice copies
- ✓ View open balances and a Pay History of your contract
- ✓ Enroll in Paperless

- ✓ Update your insurance
- ✓ Update your Billing or Asset Address
- ✓ Enroll in Direct Debit



Correspondence Address

DE LAGE LANDEN FINANCIAL SERVICES, INC.
1111 OLD EAGLE SCHOOL RD
WAYNE, PA 19087-1453

*Please provide your contract number



Customer Service

800-736-0220

Important Reminder

Enclose remittance slip with your check and send it to the address on the reverse side to ensure accurate and timely processing of your payment. **Please remit payments at least 5 days prior to due date. Please record your Invoice number on the check.**

Explanation of Charges

It is important to us that you understand the charges on your invoice. Please refer to this guide for assistance.

1. **DOCUMENTATION/ORIGINATION FEE** – A one-time fee assessed on new transactions to cover our expenses for preparing financing statements and other documentation costs.
2. **INTERIM PAYMENT** – A charge to account for the partial month, prior to the first full billing cycle, calculated per the terms and conditions in the contract.
3. **INSURANCE CHARGE** – A charge due each billing period as the result of the equipment being insured by the lessor against theft or damage.
4. **PAYMENT** – Amount due each billing period in accordance with the terms of the contract.
5. **LATE FEE** – Assessed when a payment is not received by its due date, as provided by the contract.
6. **FINANCE CHARGE** – Assessed when a payment is not received and is over thirty (30) days past its due date.
7. **PROPERTY TAX** – The lessor, as the owner of the equipment, is assessed and pays property tax to the appropriate taxing authority on an annual basis. Per the contract, the Lessee has agreed to reimburse the Lessor for all property taxes paid on their behalf plus reasonable administrative costs. For questions about taxes, call the Customer Service number above.
8. **RETURNED CHECK FEE** – Assessed each time a check is returned for any reason.
9. **CUSTOMER SERVICE FEE** – Assessed when a request for an amortization schedule, an invoice copy, a pay history or additional contract copy is requested.
10. **ACCOUNT SUMMARY** – Overview of prior billed invoices for which a partial or no payment was received at the time the current invoice was printed.
11. **TAX OR LESSOR SURCHARGE** – Taxes due in accordance with the tax laws of the state(s) where the equipment is located. For tax related questions, call the Customer Service number above.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

REMITTANCE SECTION

Invoice Number: 63957744
 Due Date: 07/01/2019
 Due This Period: \$254.00

Amount Enclosed: \$ _____

Please make check payable to:

DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602



INSIGHT PA CYBER CHARTER SCHOOL
 ATTN: AP
 350 EAGLEVIEW BLVD STE 350
 EXTON PA 19341-1198

2100000639577440000254001

Detach here. Please include the top payment coupon with your payment. Please allow 5-7 days for U.S. Postal Service delivery.



DE LAGE LANDEN FINANCIAL SERVICES, INC.
 PO BOX 41602
 PHILADELPHIA, PA 19101-1602

WWW.LESSEEDIRECT.COM

Contract Number: 500-50000488
 Invoice Number: 63957744
 Account Number: 1293803
 Site Number: 4522182
 Invoice Date: 06/08/2019
 Period of Performance: 06/01/2019-06/30/2019
 Due This Period: \$254.00

IMPORTANT MESSAGES

*Please review your equipment location(s) for tax purposes.

Visit WWW.LESSEEDIRECT.COM

- Did you know you can...
- ✓ View copies of your contract and open invoices
 - ✓ Enroll in paperless invoicing
 - ✓ Make a payment
 - ✓ Set up automated/recurring payments

See Reverse For Important Information

INVOICE DETAILS

Description	Payment Amount	Tax	Total Amount	Applied Amount	Remaining Amount Due
PAYMENT	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00
Billed this Invoice	\$254.00	\$0.00	\$254.00	\$0.00	\$254.00

(Please see the following pages for details.)

ASSET DETAILS

Contract Number	Serial Number	Purchase Order	Make / Model	Asset Number	Install Date	Cost Center	Department	Payment Amount	Tax	Total Amount
500-50000488	W378914437		Kyocera / TASKalfa 4002i	50000488_1				\$110.57	\$0.00	\$110.57
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
500-50000488	RFE9100358		Kyocera / TASKalfa 3553ci	50000488_2				\$143.43	\$0.00	\$143.43
Asset Location: 350 EAGLEVIEW BLVD STE 350 EXTON CHESTER PA 193411198 United States										
									Asset Amount Total:	\$254.00

Contact Us



WWW.LESSEEDIRECT.COM

- ✓ View contract and invoice copies
- ✓ View open balances and a Pay History of your contract
- ✓ Enroll in Paperless

- ✓ Update your insurance
- ✓ Update your Billing or Asset Address
- ✓ Enroll in Direct Debit



Correspondence Address

DE LAGE LANDEN FINANCIAL SERVICES, INC.
1111 OLD EAGLE SCHOOL RD
WAYNE, PA 19087-1453

*Please provide your contract number



Customer Service

800-736-0220

Important Reminder

Enclose remittance slip with your check and send it to the address on the reverse side to ensure accurate and timely processing of your payment. **Please remit payments at least 5 days prior to due date. Please record your Invoice number on the check.**

Explanation of Charges

It is important to us that you understand the charges on your invoice. Please refer to this guide for assistance.

1. **DOCUMENTATION/ORIGINATION FEE** – A one-time fee assessed on new transactions to cover our expenses for preparing financing statements and other documentation costs.
2. **INTERIM PAYMENT** – A charge to account for the partial month, prior to the first full billing cycle, calculated per the terms and conditions in the contract.
3. **INSURANCE CHARGE** – A charge due each billing period as the result of the equipment being insured by the lessor against theft or damage.
4. **PAYMENT** – Amount due each billing period in accordance with the terms of the contract.
5. **LATE FEE** – Assessed when a payment is not received by its due date, as provided by the contract.
6. **FINANCE CHARGE** – Assessed when a payment is not received and is over thirty (30) days past its due date.
7. **PROPERTY TAX** – The lessor, as the owner of the equipment, is assessed and pays property tax to the appropriate taxing authority on an annual basis. Per the contract, the Lessee has agreed to reimburse the Lessor for all property taxes paid on their behalf plus reasonable administrative costs. For questions about taxes, call the Customer Service number above.
8. **RETURNED CHECK FEE** – Assessed each time a check is returned for any reason.
9. **CUSTOMER SERVICE FEE** – Assessed when a request for an amortization schedule, an invoice copy, a pay history or additional contract copy is requested.
10. **ACCOUNT SUMMARY** – Overview of prior billed invoices for which a partial or no payment was received at the time the current invoice was printed.
11. **TAX OR LESSOR SURCHARGE** – Taxes due in accordance with the tax laws of the state(s) where the equipment is located. For tax related questions, call the Customer Service number above.

CONTRACT INVOICE

Invoice Number: AR235378
Invoice Date: 4/15/2019
Account Number: IC02
Balance Due: \$1,546.03

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due	
IC02	30 Days	5/15/2019	\$1,546.03	\$1,546.03	
Invoice Remarks					
Contract Number	Contact	Contract Amount	P.O. Number	Start Date	Exp. Date
CN13435-01	Accounts Payable 877-916-9149	\$1,546.03	Monthly	3/15/2019	3/14/2024
Contract Remarks					
Includes: Parts, Labor, Supplies Excludes: Paper & Staples					

Summary:

Contract base rate charge for this billing period	\$0.00
Contract overage charge for the 3/15/2019 to 4/14/2019 overage period	\$1,546.03**
	\$1,546.03

**See overage details below

Detail:

Equipment included under this contract

Kyocera/T3553

Number	Serial Number	Base Adj.	Location						
42216	RFE9100358	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Back Office						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B/W	Black Meter	80	24,726		24,646		*** See overage details below		
Color	Color Meter	6	27,823		27,817	0	27,817	0.045000	\$1,251.77 \$1,251.77

Kyocera/Mita/T4002

Number	Serial Number	Base Adj.	Location						
42218	W378914437	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Front Reception Area						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B/W	Black Meter	91	24,488		24,397		*** See overage details below		
									\$0.00

CONTRACT INVOICE

Invoice Number: AR235378
Invoice Date: 4/15/2019
Account Number: IC02
Balance Due: \$1,546.03

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton , PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due
IC02	30 Days	5/15/2019	\$1,546.03	\$1,546.03
Invoice Remarks				

Overage Details

Meter Group	Total Copies	Covered Copies	Billable	Rate	Total
Black Meter	49,043	0	0	49,043 \$0.006000	\$294.26
				Base Amount:	\$0.00
					<u>\$294.26</u>
Meter Type	Equip. Number	Serial Number	Begin	End	Copies
B\W	42216	RFE9100358	80	24,726	24,646
B\W	42218	W378914437	91	24,488	24,397
Total Grouped Overage Charges:					\$294.26
Total Grouped Base Charges:					<u>\$0.00</u>
Total Meter Group Charges:					\$294.26

Please pay from this invoice. Overdue accounts will be charged a late payment fee of 1.5% per month (18% annually) \$2.00 minimum on all balances over 15 days from receipt of invoice.

Invoice SubTotal	\$1,546.03
Tax:	\$0.00
Invoice Total	\$1,546.03
Balance Due:	\$1,546.03



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR242689
Invoice Date: 5/14/2019
Account Number: IC02
Balance Due: \$506.75

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due	
IC02	30 Days	6/13/2019	\$506.75	\$506.75	
Invoice Remarks					
Contract Number	Contact	Contract Amount	P.O. Number	Start Date	Exp. Date
CN13435-01	Accounts Payable 877-916-9149	\$506.75	Monthly	3/15/2019	3/14/2024
Contract Remarks					
Includes: Parts, Labor, Supplies Excludes: Paper & Staples					

Summary:

Contract base rate charge for this billing period	\$0.00
Contract overage charge for the 4/15/2019 to 5/14/2019 overage period	\$506.75**
	\$506.75

**See overage details below

Detail:

Equipment included under this contract

Kyocera/T3553

Number	Serial Number	Base Adj.	Location						
42216	RFE9100358	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Back Office						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	24,726	31,680		6,954				*** See overage details below
Color	Color Meter	27,823	37,263		9,440	0	9,440	0.045000	\$424.80 \$424.80

Kyocera/Mita/T4002

Number	Serial Number	Base Adj.	Location						
42218	W378914437	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Front Reception Area						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	24,488	31,192		6,704				*** See overage details below
									\$0.00



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR242689
Invoice Date: 5/14/2019
Account Number: IC02
Balance Due: \$506.75

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due
IC02	30 Days	6/13/2019	\$506.75	\$506.75
Invoice Remarks				

Overage Details						
Meter Group	Total Copies	Covered Copies	Billable	Rate	Total	
Black Meter	13,658	0	0	13,658	\$0.006000	\$81.95
					Base Amount:	\$0.00
						\$81.95
Meter Type	Equip. Number	Serial Number	Begin	End	Copies	
B\W	42216	RFE9100358	24,726	31,680	6,954	
B\W	42218	W378914437	24,488	31,192	6,704	
Total Grouped Overage Charges:						\$81.95
Total Grouped Base Charges:						\$0.00
Total Meter Group Charges:						\$81.95

Please pay from this invoice. Overdue accounts will be charged a late payment fee of 1.5% per month (18% annually) \$2.00 minimum on all balances over 15 days from receipt of invoice.

Invoice SubTotal	\$506.75
Tax:	\$0.00
Invoice Total	\$506.75
Balance Due:	\$506.75



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR249623
Invoice Date: 6/13/2019
Account Number: IC02
Balance Due: \$300.06

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due	
IC02	30 Days	7/13/2019	\$ 300.06	\$ 300.06	
Invoice Remarks					
Contract Number	Contact	Contract Amount	P.O. Number	Start Date	Exp. Date
CN13435-01	Accounts Payable 877-916-9149	\$ 300.06	Monthly	3/15/2019	3/14/2024
Contract Remarks					
Includes: Parts, Labor, Supplies Excludes: Paper & Staples					

Summary:

Contract base rate charge for this billing period	\$0.00
Contract overage charge for the 5/15/2019 to 6/14/2019 overage period	\$300.06 **
	\$300.06

**See overage details below

Detail:

Equipment included under this contract

Kyocera/T3553

Number	Serial Number	Base Adj.	Location
42216	RFE9100358	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Back Office

Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	31,680	34,158		2,478				*** See overage details below
Color	Color Meter	37,263	43,272		6,009	0	6,009	0.045000	\$270.41
									\$270.41

Kyocera/Mita/T4002

Number	Serial Number	Base Adj.	Location
42218	W378914437	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Front Reception Area

Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	31,192	33,656		2,464				*** See overage details below
									\$0.00



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR249623
Invoice Date: 6/13/2019
Account Number: IC02
Balance Due: \$300.06

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due
IC02	30 Days	7/13/2019	\$ 300.06	\$ 300.06
Invoice Remarks				

Overage Details						
Meter Group	Total Copies	Covered Copies	Billable	Rate	Total	
Black Meter	4,942	0	0	4,942	\$0.006000	\$29.65
					Base Amount:	\$0.00
						\$29.65
Meter Type	Equip. Number	Serial Number	Begin	End	Copies	
B\W	42216	RFE9100358	31,680	34,158	2,478	
B\W	42218	W378914437	31,192	33,656	2,464	
Total Grouped Overage Charges:						\$29.65
Total Grouped Base Charges:						\$0.00
Total Meter Group Charges:						\$29.65

Please pay from this invoice. Overdue accounts will be charged a late payment fee of 1.5% per month (18% annually) \$2.00 minimum on all balances over 15 days from receipt of invoice.

Invoice SubTotal	\$300.06
Tax:	\$0.00
Invoice Total	\$300.06
Balance Due:	\$300.06

P.O. Box 684 Pennsauken, NJ 08110 1.800.422.7411



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR255515
Invoice Date: 7/9/2019
Account Number: IC02
Balance Due: \$193.54

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton , PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due	
IC02	30 Days	8/8/2019	\$193.54	\$193.54	
Invoice Remarks					
Contract Number	Contact	Contract Amount	P.O. Number	Start Date	Exp. Date
CN13435-01	Accounts Payable 877-916-9149	\$193.54	Monthly	3/15/2019	3/14/2024
Contract Remarks					
Includes: Parts, Labor, Supplies Excludes: Paper & Staples					

Summary:

Contract base rate charge for this billing period	\$0.00
Contract overage charge for the 6/15/2019 to 7/14/2019 overage period	\$193.54**
	\$193.54

**See overage details below

Detail:

Equipment included under this contract

Kyocera/T3553

Number	Serial Number	Base Adj.	Location						
42216	RFE9100358	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Back Office						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	34,158	36,189		2,031		*** See overage details below		
Color	Color Meter	43,272	46,964		3,692	0	3,692	0.045000	\$166.14
									\$166.14

Kyocera/Mita/T4002

Number	Serial Number	Base Adj.	Location						
42218	W378914437	\$0.00	Insight Cyber Charter School 350 Eagleview Blvd Suite 350 Exton, PA 19341 Front Reception Area						
Meter Type	Meter Group	Begin Meter	End Meter	Credits	Total	Covered	Billable	Rate	Overage
B\W	Black Meter	33,656	36,192		2,536		*** See overage details below		
									\$0.00



1263 Glen Avenue • Moorestown, NJ 08057
 Phone: (800) 422-7411 • Fax: (856) 722-1161
 www.heritagebusiness.com

CONTRACT INVOICE

Invoice Number: AR255515
Invoice Date: 7/9/2019
Account Number: IC02
Balance Due: \$193.54

Bill To: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Customer: Insight Cyber Charter School
 350 Eagleview Blvd Suite 350
 Exton, PA 19341

Account No	Payment Terms	Due Date	Invoice Total	Balance Due
IC02	30 Days	8/8/2019	\$193.54	\$193.54
Invoice Remarks				

Overage Details

Meter Group	Total Copies	Covered Copies	Billable	Rate	Total
Black Meter	4,567	0	0	4,567 \$0.006000	\$27.40
				Base Amount:	\$0.00
					<u>\$27.40</u>
Meter Type	Equip. Number	Serial Number	Begin	End	Copies
B\W	42216	RFE9100358	34,158	36,189	2,031
B\W	42218	W378914437	33,656	36,192	2,536
Total Grouped Overage Charges:					\$27.40
Total Grouped Base Charges:					<u>\$0.00</u>
Total Meter Group Charges:					\$27.40

Please pay from this invoice. Overdue accounts will be charged a late payment fee of 1.5% per month (18% annually) \$2.00 minimum on all balances over 15 days from receipt of invoice.

Invoice SubTotal	\$193.54
Tax:	\$0.00
Invoice Total	\$193.54
Balance Due:	\$193.54

Jones, Beth (ISPA Admin)

From: Salindong, Jaime <jsalindong@k12.com>
Sent: Monday, July 29, 2019 5:09 PM
To: Jones, Beth (ISPA Admin)
Subject: RE: for the charter renewal

Hi Beth,

We had permission to short by the De Lage Landed (Heritage) invoice. See below we only paid \$254

Based on: Document date	As of date: 07/29/2019		
Vendor	Date	Document	Ref
635 - DE LAGE LANDEN FINANCIAL SERVICES	04/17/2019	63122885-ISPA	631
	04/18/2019	11081	
	05/20/2019	63495162-ISPA	634
	05/22/2019	11223	
	06/13/2019	63957744-ISPA	639
	06/17/2019	11348	
	07/11/2019	64211785-ISPA	642
	07/12/2019	11460	
Total For DE LAGE LANDEN FINANCIAL SERVICES			

Thanks.

JAIME SALINDONG
Senior Finance Manager
Insight PA Cyber Charter School



☎ 484.713.4353 x 2011 | ☎ 844.269.9230 x2011
jsalindong@K12.com | K12.com

350 Eagleview Blvd., Suite 350
Exton, PA 19341



From: Jones, Beth (ISPA Admin) [mailto:bjones@insightpa.org]
Sent: Monday, July 29, 2019 2:01 PM

Lease invoice# 3305399776

January 31, 2018

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$46.42
TOTAL DUE 03/02/2018	\$819.97
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION

Payment of \$819.97 is due by March 2, 2018



Pay online
pitneybowes.us/signin



Pay by mail with
attached coupon



Pay by Phone
800-732-7222

Questions on your invoice?


- Please see the line item details on the following pages.
- **NEW!** Go to your personalized video for a review of your invoice at pitneybowes.com/us/yourbill
- Or you can call 800-732-7222 Monday-Friday 8AM-8PM EST

Additional important information follows the invoice details.

Manage your account online for 24/7 access to view and pay bills

- Ensure on time payments by signing up for automatic payments.
- It's efficient, easy, secure and the best part about it – there's no extra charge.

Get started at pitneybowes.us/signin



New USPS® rates in effect.
Is your meter updated?

- New rates took effect January 21, 2018.
- First-Class Mail® Letters (up to 1oz) are now 50¢.
- Meter users only pay 47¢.

To pay by mail, please complete and send the coupon below. Please allow 7-10 days for mail and processing time.

Page 1 of 2

TAX ID 20-1344287

Tear off here

N-013739

Pitney Bowes
 2225 American Drive
 Neenah, WI 54956-1005
 0601010137390000100101312018

Pitney Bowes payment coupon
 If you've chosen to pay by mail, please include this payment coupon with your payment.

Account #: 0018229748
 Invoice date: Jan 31, 2018
 Payment amount due: **\$819.97**

Invoice #: 3305399776
 Due date: Mar 02, 2018

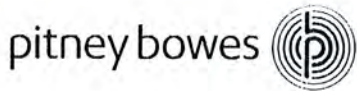


2000001822974813305399776400008199709

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198



Account number
0018229748

Invoice number
3305399776

Invoice date
January 31, 2018

DETAILS OF YOUR CHARGES

Contract # 0040695392 Billing period: 01/29/2018 - 04/28/2018 Totals

Location account: 0018229748

Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198

Description	Total
DM400C Digital Mailing System	\$773.55
Product/Serial #: G900 / 0914054	
Meter for DM300/DM400/475 Series	
Product/Serial #: MP9G / 0274628	
Integrated Weighing Platform	
	State tax \$46.42
Contract # 0040695392 Total	\$819.97
TOTAL DUE	\$819.97



0601010137390000100101312018

Important information

Access the following activities on our website:

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 800-732-7222
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3305875068

April 1, 2018

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 05/01/2018	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION

Payment of \$773.55 is due by May 1, 2018



Pay online
pitneybowes.us/signin



Pay by mail with attached coupon



Pay by Phone
800-732-7222

Questions on your invoice?


- Please see the line item details on the following pages.
- **NEW!** Go to your personalized video for a review of your invoice at pitneybowes.com/us/yourbill
- Or you can call 800-732-7222 Monday-Friday 8AM-8PM EST

Additional important information follows the invoice details.

Manage your account online for 24/7 access to view and pay bills

- Ensure on time payments by signing up for automatic payments.
- It's efficient, easy, secure and the best part about it - there's no extra charge.

Get started at pitneybowes.us/signin



New USPS® rates in effect.
Is your meter updated?

- New rates took effect January 21, 2018.
- First-Class Mail® Letters (up to 1oz) are now 50¢.
- Meter users only pay 47¢.

To pay by mail, please complete and send the coupon below. Please allow 7-10 days for mail and processing time.

Page 1 of 2

TAX ID 20-1344287

Tear off here

N-001950

Pitney Bowes
 2225 American Drive
 Neenah, WI 54956-1005
 0601040019500000100104012018

Pitney Bowes payment coupon
 If you've chosen to pay by mail, please include this payment coupon with your payment.

Account #: 0018229748
Invoice date: Apr 1, 2018
Payment amount due: \$773.55

Invoice #: 3305875068
Due date: May 01, 2018

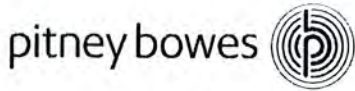
--	--	--	--

2000001822974813305875068900007735508

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198



Account number
0018229748

Invoice number
3305875068

Invoice date
April 1, 2018

DETAILS OF YOUR CHARGES

Contract # 0040695392

Billing period: 04/29/2018 - 07/28/2018

Totals

Location account: 0018229748

Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198

Description

DM400C Digital Mailing System

Total

\$773.55

Product/Serial #: G900 / 0914054

Meter for DM300/DM400/475 Series

Product/Serial #: MP9G / 0274628

Integrated Weighing Platform

Total tax

\$0.00

Contract # 0040695392 Total

\$773.55

TOTAL DUE

\$773.55



0601040019500000100104012018

Important information

Access the following activities on our website:

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 800-732-7222
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3306563405

June 30, 2018

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 07/29/2018	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION
 Payment of \$773.55 is due by July 29, 2018



Sign up.

Never need to pick up the phone again. Sign up to "Your Account" to manage everything online.
pitneybowes.com/us/signupnow



Pay online.

Start using "Your Account" today to manage everything online, including AutoPay.
pitneybowes.com/us/payonlinenow



Questions?

Get immediate answers to your questions.
pitneybowes.com/us/answers

For Billing and Account Support call: 844-256-6444

NEW: Check your lease contract details at
pitneybowes.com/us/contract

To pay by mail, please complete and send the coupon below. Please allow 7-10 days for mail and processing time.

Page 1 of 2

TAX ID 20-1344287

Tear off here

N-000360

Pitney Bowes

2225 American Drive
Neenah, WI 54956-1005

0601030003600000100106302018

Pitney Bowes payment coupon

If you've chosen to pay by mail, please include this payment coupon with your payment.

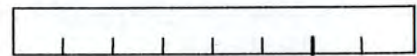
Account #: 0018229748

Invoice date: Jun 30, 2018

Payment amount due: **\$773.55**

Invoice #: 3306563405

Due date: Jul 29, 2018



2000001822974813306563405800007735503

0018229748

DETAILS OF YOUR CHARGES

Contract # 0040695392

Billing period: 07/29/2018 - 10/28/2018

Totals

Location account: 0018229748

Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198

Description**DM400C Digital Mailing System**

Product/Serial #: G900 / 0914054

Meter for DM300/DM400/475 Series

Product/Serial #: MP9G / 0274628

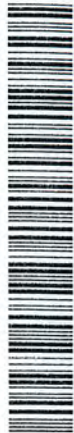
Integrated Weighing Platform

Total

\$773.55

Total tax

\$0.00

Contract # 0040695392 Total**\$773.55****TOTAL DUE****\$773.55**

0601030003600000100106302018

Important information**Access the following activities on our website:**

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

Page 2 of 2

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 844-256-6444
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3309212150

June 29, 2019

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 07/29/2019	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION

Payment of \$773.55 is due by July 29, 2019



Sign up.

Never need to pick up the phone again. Sign up to "Your Account" to manage everything online.
pitneybowes.com/us/signupnow



Pay online.

Start using "Your Account" today to manage everything online, including AutoPay.
pitneybowes.com/us/payonlinenow



Questions?

Get immediate answers to your questions.
pitneybowes.com/us/answers

For Billing and Account Support call: 844-256-6444



Let us finance your next purchase. Introducing Wheeler Financial™ from Pitney Bowes
wheelerfinancial.com

NEW: Check your lease contract details at
pitneybowes.com/us/contract

To pay by mail, complete and send the coupon below. Please allow 7-10 business days for mail and processing time.

Page 1 of 2

TAXID 20-1344287

V

Tear off here

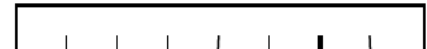
N-043765

Pitney Bowes
 2225 American Drive
 Neenah, WI 54956-1005

Pitney Bowes payment coupon
 If you've chosen to pay by mail, please include this payment coupon with your payment.

Account #: 0018229748
 Invoice date: Jun 29, 2019
 Payment amount due: **\$773.55**

Invoice #: 3309212150
 Due date: Jul 29, 2019



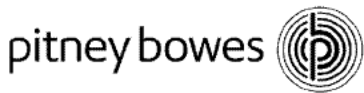
2000001822974813309212150900007735509

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198

Change of address/contact information?
 Please update at pitneybowes.com/us/support/addresschange.



Account number
0018229748

Invoice number
3309212150

Invoice date
June 29, 2019

DETAILS OF YOUR CHARGES

Contract # 0040695392

Billing period: 07/29/2019 - 10/28/2019

Totals

Location account: 0018229748

Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198

Description

DM400C Digital Mailing System

Total

\$773.55

- Product/Serial #: G900 / 0914054
Meter for DM300/DM400/475 Series
- Product/Serial #: 4CES / 0914054
DM400C Base U.S. ES2
- Product/Serial #: MP9G / 0274628
Integrated Weighing Platform

Total tax \$0.00

Contract # 0040695392 Total

\$773.55

TOTAL DUE

\$773.55

Important information

Access the following activities on our website:

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 844-256-6444
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3307222353

September 30, 2018

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 10/29/2018	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION

Payment of \$773.55 is due by October 29, 2018



Sign up.

Never need to pick up the phone again. Sign up to "Your Account" to manage everything online.

pitneybowes.com/us/signupnow



Pay online.

Start using "Your Account" today to manage everything online, including AutoPay.

pitneybowes.com/us/payonlinenow



Questions?

Get immediate answers to your questions.

pitneybowes.com/us/answers

For Billing and Account Support call: 844-256-6444

NEW: Check your lease contract details at
pitneybowes.com/us/contract

To pay by mail, complete and send the coupon below. Please allow 7-10 business days for mail and processing time.

Page 1 of 2

TAXID 20-1344287

V

Tear off here

N-046917

Pitney Bowes

2225 American Drive
 Neenah, WI 54956-1005

Pitney Bowes payment coupon

If you've chosen to pay by mail, please include this payment coupon with your payment.

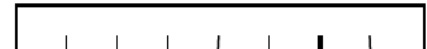
Account #: 0018229748

Invoice date: Sep 30, 2018

Payment amount due: **\$773.55**

Invoice #: 3307222353

Due date: Oct 29, 2018



2000001822974813307222353100007735502

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198

Change of address/contact information?

Please update at pitneybowes.com/us/support/addresschange.

DETAILS OF YOUR CHARGES

Contract # 0040695392	Billing period: 10/29/2018 - 01/28/2019	Totals
Location account: 0018229748 Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198		
Description		Total
DM400C Digital Mailing System		\$773.55
Product/Serial #: G900 / 0914054		
Meter for DM300/DM400/475 Series		
Product/Serial #: MP9G / 0274628		
Integrated Weighing Platform		
	Total tax	\$0.00
	Contract # 0040695392 Total	\$773.55
	TOTAL DUE	\$773.55

Important information

Access the following activities on our website:

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 844-256-6444
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3307916332

December 31, 2018

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 01/29/2019	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION
 Payment of \$773.55 is due by January 29, 2019



Sign up.

Never need to pick up the phone again. Sign up to 'Your Account' to manage everything online.

pitneybowes.com/us/signupnow



Pay online.

Start using 'Your Account' today to manage everything online, including AutoPay.

pitneybowes.com/us/payonlinenow



Questions?

Get immediate answers to your questions.

pitneybowes.com/us/answers

For Billing and Account Support call: 844-256-6444

NEW: Check your lease contract details at
pitneybowes.com/us/contract

To pay by mail, complete and send the coupon below. Please allow 7-10 business days for mail and processing time.

Page 1 of 2

TAX ID 20-1344287

V

Tear off here

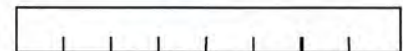
N-002722

Pitney Bowes
 2225 American Drive
 Neenah, WI 54956-1005

Pitney Bowes payment coupon
 If you've chosen to pay by mail, please include this payment coupon with your payment.

Account #: 0018229748
 Invoice date: Dec 31, 2018
 Payment amount due: **\$773.55**

Invoice #: 3307916332
 Due date: Jan 29, 2019



2000001822974813307916332600007735504

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198

Change of address/contact information?
 Please update at pitneybowes.com/us/support/addresschange.

DETAILS OF YOUR CHARGES

Contract # 0040695392	Billing period: 01/29/2019 - 04/28/2019	Totals
-----------------------	---	--------

Location account: 0018229748

Location: Insight PA Cyber Charter Schoo, L, 350 Eagleview Blvd, Ste 350, Exton, PA 193411198

Description	Total
DM400C Digital Mailing System	\$773.55
Product/Serial #: G900 / 0914054	
Meter for DM300/DM400/475 Series	
Product/Serial #: MP9G / 0274628	
Integrated Weighing Platform	
	Total tax \$0.00
	Contract # 0040695392 Total \$773.55
	TOTAL DUE \$773.55

Important information

Access the following activities on our website:

- View and pay bills
- Order Supplies
- Update account information
- Access technical support

It's easy. Go to pitneybowes.us/signin

This transaction is governed by the terms and conditions of the applicable Pitney Bowes agreement, current as of the date of this invoice unless otherwise agreed to in writing by the parties.

Payment

If we do not receive your payment by the Payment Due Date, late fees will apply. If your payment is returned, you're liable for any charges we incur. If you make a partial payment of the payment due, it doesn't change your contract or obligations to us.

You can pay your bill:

- Online at pitneybowes.us/signin
- By credit card, over the phone at 844-256-6444
- By check, made payable to Pitney Bowes Global Financial Services LLC and sent with this *payment coupon* to:
PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
PO BOX 371887
PITTSBURGH PA 15250-7887

Lease invoice# 3308555625

March 30, 2019

SUMMARY OF YOUR CHARGES	
Leasing charges	\$773.55
Total tax	\$0.00
TOTAL DUE 04/29/2019	\$773.55
<i>See reverse side for invoice details.</i>	

PAYMENT INFORMATION
 Payment of \$773.55 is due by April 29, 2019



Never need to pick up the phone again. Sign up to 'Your Account' to manage everything online.
pitneybowes.com/us/signupnow

Sign up.



Start using 'Your Account' today to manage everything online, including AutoPay.
pitneybowes.com/us/payonlinenow

Pay online.



Get immediate answers to your questions.
pitneybowes.com/us/answers

Questions?

For Billing and Account Support call: 844-256-6444

NEW: Check your lease contract details at
pitneybowes.com/us/contract

To pay by mail, complete and send the coupon below. Please allow 7-10 business days for mail and processing time.

Page 1 of 2

TAXID 20-1344287

V

Tear off here

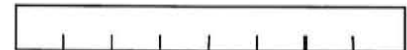
N-046871

Pitney Bowes
 2225 American Drive
 Neenah, WI 54956-1005

Pitney Bowes payment coupon
 If you've chosen to pay by mail, please include this payment coupon with your payment.

Account #: 0018229748
Invoice date: Mar 30, 2019
Payment amount due: \$773.55

Invoice #: 3308555625
Due date: Apr 29, 2019



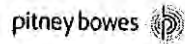
2000001822974813308555625700007735503

0018229748

PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC
 PO BOX 371887
 PITTSBURGH PA 15250-7887

INSIGHT PA CYBER CHARTER SCHOO
 L
 ANGELA DECKER
 350 EAGLEVIEW BLVD
 STE 350
 EXTON PA 19341-1198

Change of address/contact information?
 Please update at pitneybowes.com/us/support/addresschange.



Lease Agreement

0040695392

Agreement Number

Your Business Information

Full Legal Name of Lessee / DBA Name of Lessee

Tax ID # (FEIN/TIN)

Insight PA Cyber Charter School

461166314

Sold-To: Address

350 Eagleview Blvd Ste 350, Exton, PA, 19341-1198, US

Sold-To: Contact Name

Sold-To: Contact Phone #

Sold-To: Account #

Angela Decker

(484) 713-4353

0018229748

Bill-To: Address

350 Eagleview Blvd Ste 350, Exton, PA, 19341-1198, US

Bill-To: Contact Name

Bill-To: Contact Phone #

Bill-To: Account #

Bill-To: Email

Angela Decker

(484) 713-4353

0018229748

adecker@k12.com

Ship-To: Address

350 Eagleview Blvd Ste 350, Exton, PA, 19341-1198, US

Ship-To: Contact Name

Ship-To: Contact Phone #

Ship-To: Account #

Angela Decker

(484) 713-4353

0018229748

PO #

Your Business Needs

Qty	Item	Business Solution Description
1	DM400C	DM400C Digital Mailing System
1	1FAL	INVIEW 50 DEPT Accounting
1	1FXA	1FXA DM Series INVIEW Dashboard
1	1FY8	DM400 95 LPM
1	1FZ0	Differential Weighing
1	1GW5	5lb Integrated Weighing Feature
1	4CES	US LIVE DM400C BASE - ES2
1	G900	Meter for DM300/DM400/475 Series
1	G9SS	USPS Tracking Services Activation
1	HS9E	SENDPRO DESKTOP SENDKIT
1	MPOX	Differential Weigh 2, 5, & 10lb scale
1	MP9G	Integrated Weighing Platform
1	NV10	INVIEW TMR Web Acct Bundle Single only
1	NV90	NV90 - INVIEW Subscription

0040695392

1	NV90KIT	Inview Welcome Kit
1	NV99	INVIEW MMS Base Software
1	NV99KIT	Inview Welcome Kit
1	PTJ1	Postal Shipping
1	PTJ4	Multicarrier Sending App w/HW or Meter
1	PTJ8	SENDPRO MAILING INCLUDED W/ HW
1	PTJC	SendPro Individual
1	PTJN	SINGLE USER ACCESS
1	PTK1	WEB BROWSER INTEGRATION
1	SBTA	DM400C Digital Meter System
1	SJ40	SoftGuard for DM400
1	SL-SPMWK01	SENDPRO MAILING WELCOME KIT
1	STDSLA	Standard SLA-Equipment Service Agreement (for DM400C Digital Mailing System)
1	SV5A	DM Series Analytics (50 Accounts)
1	WIF4	DM Series WiFi Option - POINT OF SALE

Your Payment Plan

Initial Term: 63 months	Initial Payment Amount:	
Number of Months	Monthly Amount	Billed Quarterly at*
63	\$ 257.85	\$ 773.55

*Does not include any applicable sales, use, or property taxes which will be billed separately.

- Tax Exempt Certificate Attached
 Tax Exempt Certificate Not Required
 Purchase Power® transaction fees included
 Purchase Power® transaction fees extra

0040695392

Your Signature Below

By signing below, you agree to be bound by all the terms of this Agreement including the Pitney Bowes Terms (Version 10/17), which are available at <http://www.pb.com/termsconditions> and are incorporated by reference. You acknowledge that you may not cancel the lease for any reason and that all payment obligations are unconditional. The lease will be binding on us after we have completed our credit and documentation approval process and have signed below. The lease requires you either to provide proof of insurance or participate in the ValueMAX® equipment protection program (see Section 16 of the Pitney Bowes Terms) for an additional fee. If software is included in the Order, additional terms apply which are available by clicking on the hyperlink for that software located at <http://www.pitneybowes.com/us/license-terms-of-use/software-and-subscription-terms-and-conditions.html>. Those additional terms are incorporated by reference.

Not Applicable

State/Entity's Contract#

Eileen Cannistraci
Lessee Signature
Eileen Cannistraci
Print Name
CEO
Title
1/17/18
Date
eicannistraci@insightpa.org
Email Address

Salvatore Polletta
Pitney Bowes Signature
Salvatore Polletta
Print Name
Title
Director, Credit & New Business Operat
Date

Thursday, January 18, 2018

Sales Information

Michael Gibson

michael.gibson@pb.com

Account Rep Name

Email Address



INSIGHT PA
CYBER CHARTER SCHOOL

POWERED BY K12

Insight Pennsylvania Cyber Charter School (ISPA) Special Education Procedural Manual:

2019-2020

Table of Contents

Introduction	5
Insight PA’s Virtual Learning Model – “Public School at Home”	5
Technical Support	6
School Calendar & Important Dates	7
Quarterly Report Card & IEP Progress Reporting	7
PA State Assessments	8
Extended School Year (ESY)	8
ISPA Student Conduct & Family Cooperation	10
Acceptable Use Policy	11
Hazing Policy	11
Attendance, Engagement & Family Involvement	12
Student Attendance Policy	13
Attendance at Insight Pennsylvania	13
Learning Coach Responsibilities	13
Student Responsibilities	14
ISPA School Attendance Policies & Expectations	14
School Attendance	15
Non-Discrimination Policy	15
Student Records Maintenance & Transfer	15
Confidentiality & Educational Privacy	15
Family Educational Rights and Privacy Act (FERPA)	15
Special Education Records	16
Incoming Transfer Records	16
ISPA Process: Incoming Records	17
Outgoing Records Transfer	17
Notification of Withdrawal	17
Maintenance of Educational Records	18
Special Education Guidelines	18
Child Find	18
Special Education Query at Enrollment	18
Identification & Eligibility	19
Least Restrictive Environment (LRE)	19
Special Education Continuum of Services	20
Educational Placement	20

Age Range	21
Cyclical Monitoring for Continuous Improvement (CMCI)	21
Corrective Action Plan for Continuous Improvement	22
Support for School Personnel	23
Procedural Safeguards	23
Authority of Parents and/or Surrogate Parents for Educational Decision-Making	23
Prior Written Notice	23
Independent Educational Evaluation:	24
Complaint and Mediation Resources	24
Due Process	24
Manifestation Determination	24
Alternative Placement	24
Surrogate Parents for Educational Decision-Making	25
Special Education Eligibility Determination	26
Multidisciplinary Student Evaluation	26
Initial Evaluation Process & Timelines	27
Initial Evaluation Timelines	29
Re-Evaluation Timelines	30
Mandatory PA State Testing	30
PA State System of Assessment (PSSA)	31
Keystone Exams	31
PA Alternate System of Assessment (PASA)	31
PASA Eligibility Criteria	32
State Testing Accommodations	35
Post-secondary Transition	35
Graduation Options for Students with Disabilities	35
Participation in Graduation Ceremonies	36
Termination of the Right to a FAPE	36
Age of Eligibility & Extended School Year	36
Transfer of Rights	37
Educational Benefit Review (EBR)	37
Positive Behavior Support & Discipline	38
Disciplinary Exclusions: Suspensions & Expulsions	38
Alternatives to Suspension & Expulsion	38
Alternatives to Consequences	38
Strategies for Preventing Suspension & Expulsion	39

Manifestation Determination	39
Functional Behavior Assessment (FBA)	40
Conducting an FBA along with an Initial Evaluation or Reevaluation	41
Use & Reporting of Restraints	41
PA Definition of Restraint	41
IEP Progress Reports	42
Extended School Year Services (ESY)	43
ESY Eligibility Criteria:	44
ESY Determination & The Armstrong Group:	44
Notification for ESY Determinations:	44
Exit from or Parent Revocation of Special Education Services	45
IEP Meeting Participants	46
Related Services	47
Assistive Technology	48
Accessible Instructional Materials	48
PDE Resource for AIM	48
AIM Acquisition Sources	48
Resources for Learning More About AIM	49
Special Education Grievances & Dispute Resolution	50
Alternate Options Prior to Due Process	50
Formal Due Process Hearings	50
Disputes Regarding Manifestation Determinations	50
Pendency	51
Exceptions to Pendency	51
Special Education Disputes: Resource Links	52

Introduction

Under the provisions of its public-school charter issued by the Pennsylvania State Department of Education (PDE), Insight PA Cyber Charter School (ISPA) must adhere to federal and state guidelines to provide a free and appropriate public education (FAPE) to students eligible for special education services. Within the guidelines issued by the Pennsylvania State Department of Education (PDE), cyber charter schools are required to observe Chapter 711 of the 22 PA Code (see link below) in developing and sustaining practices when educating school age students with disabilities.

Insight PA is directed by a Board-appointed Chief Executive Officer (CEO), as well as an administrative Executive Director (ED). Insight PA's department of Special Education is managed by a Director of Special Education Compliance in conjunction with a Director of Academics. All staff delivering general or special education instruction are supervised directly by their respective School Principal at their assigned elementary, middle, or high school level.

K12 Inc., an international educational management company contracted by Insight PA's Board of Directors to manage the special education department, provides support and guidance to ISPA's Director of Special Education Compliance and other locally assigned administrators by its Regional and National support framework. Additionally, the K12 team supports the preliminary logistics of student enrollment from the point of a family's initial inquiry, to the completion of all PA-required documents for public school enrollment.

Insight PA takes steps to ensure supplementary aids and/or services are regularly reviewed upon enrollment (when applicable), at prescribed target dates, and as new concerns or patterns arise, so that as students grow and change, their program can be adjusted to meet updated needs for support. This special education manual serves as a basis for outlining the operational procedures ISPA has adopted for the implementation of supports and services for students with one or more known or suspected disabilities.

Insight PA's Virtual Learning Model – “Public School at Home”

ISPA is a PDE-approved cyber (or virtual) charter school where the core learning environment, curricular platform, and live instructional delivery is almost exclusively computer-based and internet-dependent. Although the instruction at ISPA is routinely delivered to students within their homes, ISPA reserves the responsibility to oversee and serve the educational program on behalf of all students enrolled; regardless of a family's chosen physical site for their child's daily school attendance & engagement. This model of virtual, public education differs *greatly* from a “homeschooling,” or “home education program.” This point is specifically noted as it is a common misperception that many families, who strive to implement a “homeschooling model,” for their child, find surprising to learn.

Insight PA (ISPA) is NOT a “homeschooling” or a “home education program” model. The following graphic provides an abbreviated visual comparison:

Homeschool	Virtual School
Parent-directed	Public school-directed
Curriculum choices by parent	Curriculum choices by school system
Faith-based curriculum okay	Faith-based curriculum not allowed
Work at student's pace and development	Work at predetermined pace and level
Student-based program	SOL test-based program

Virtual or Cyber Charter School Model: Parents accept the public-school curriculum chosen by the state. This curriculum reflects the knowledge, skills, educational standards, their child must acquire by subject or specialty area. Most students within a virtual school program progress through the curriculum along with a predetermined, estimated pacing guide in order to meet the benchmarks of the standards of learning (SOL) tests. The formal statewide assessments that ultimately measure overall student growth on SOL for each PA public school include

ISPA →

PSSA/PASA/Keystone Exams. More information regarding these state assessments are included on page A PDE certified teacher oversees the records and progress of the student, and faith-based curriculum cannot be included.

NOT ISPA →

Homeschooling or home education model: Parent-directed education in which parents choose an individualized curriculum that complements their child’s learning style and imparts the knowledge, skills, attitudes, and values they choose.

RESOURCE LINK: PDE regulations surrounding Homeschooling or Home Education Programs are found [here](#). For additional information regarding our school model, please explore [Facts About K12 Public Virtual Schools](#).

Technical Support

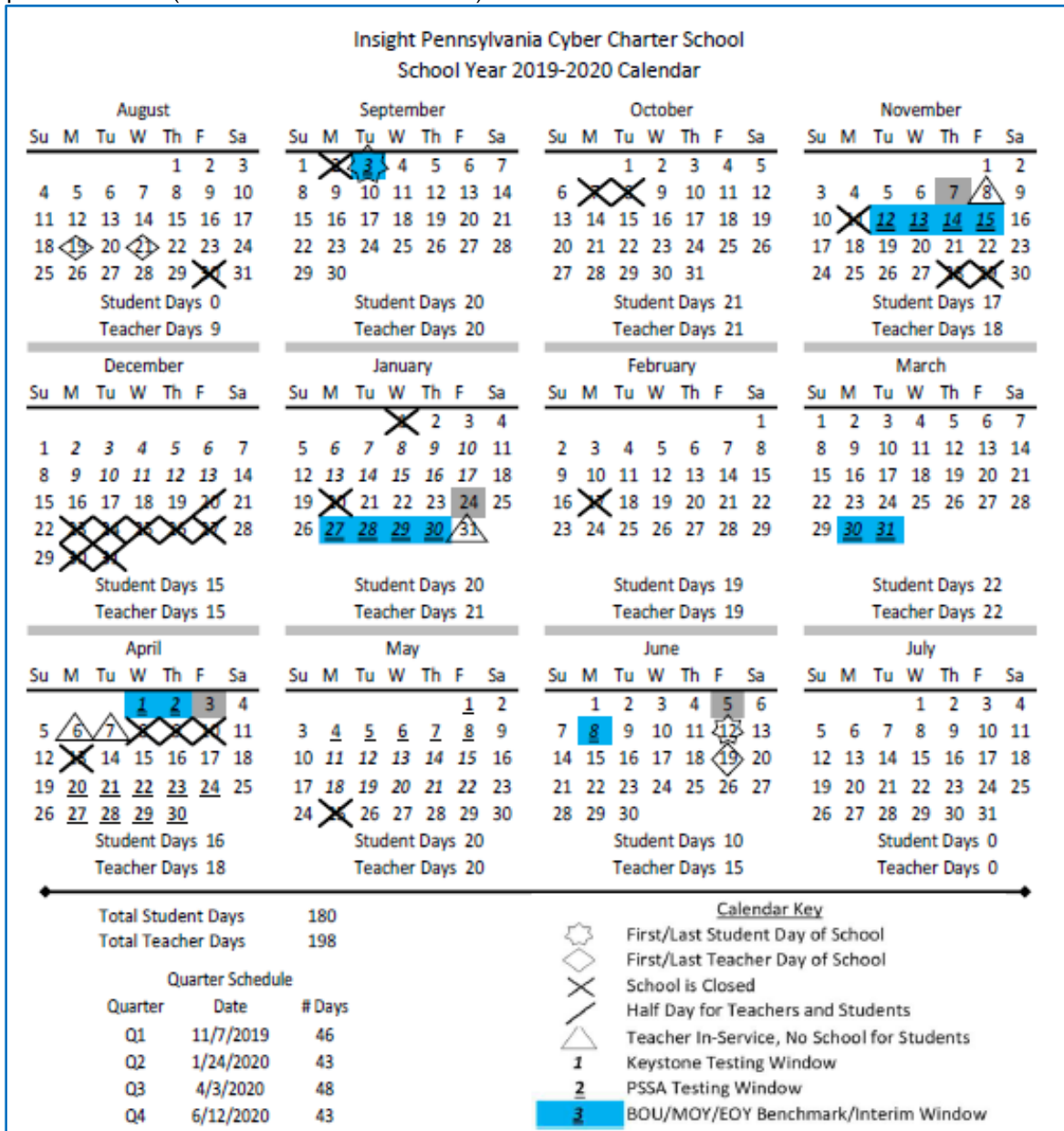
For any difficulties or barriers including the following examples...

- Missing, Lost or Damaged Course Materials
- Online School Login and Navigation
- School Email/Office 365 Help
- Report an Issue within the K12 Curriculum or within the Online School

...ISPA Families are advised to access the following link – [Form to Request Technical Support](#)

School Calendar & Important Dates

The following graphic is the approved ISPA school calendar for the 2019-2020 school year. There are 180 total number of school days scheduled for the regular school-wide calendar; however Extended School Year dates may also apply for certain students who require it as part of their IEP (See ESY for more information).



Quarterly Report Card & IEP Progress Reporting

Special education teachers serve as “Case Managers” for students assigned to their caseload. As part of this responsibility, Case Managers capture periodic updates of progress on their students’ individual IEP goals and provide a report on this progress on, at minimum, a quarterly basis. Report card grades and progress reports for IEP goals will be distributed on or shortly after the below quarter-end dates:

Quarter Schedule		
Quarter	Date	# Days
Q1	11/7/2019	46
Q2	1/24/2020	43
Q3	4/3/2020	48
Q4	6/12/2020	43

Please review the Reporting of IEP Progress section of this manual for further details regarding quarterly reporting of student progress on their IEP goals.

PA State Assessments

There are 3 different PA State Assessments that are mandated by the PA Department of Education (PDE) for all students within particular grade levels.

PSSA – The Pennsylvania System of School Assessment (PSSA) is the general form of the assessment for students in grades 3-8 and it assesses English/Language Arts (ELA), Mathematics, and for grades 4 and 8, Science. The preliminary dates for the administration of the PSSA for all public schools within the Commonwealth of PA are shown on the graphic below:

Preliminary PSSA Testing Window 2019-2020		
Assessment	Dates	Grade(s)
English Language Arts	April 20-24, 2020	Grades 3-8
Mathematics, Science and Make-ups	April 27-May 8, 2020	Grades 3-8

PASA – The Pennsylvania Alternate System of Assessment (PASA) is a statewide alternate assessment designed for students with the most significant cognitive disabilities. Students that require this form of the state assessment must meet eligibility criteria confirming they are unable to participate meaningfully in the PSSA. **As of the Spring of 2019, the anticipated dates for the PASA testing window have not yet been finalized by PDE.**

KEYSTONE EXAMS – The Keystone Exams are end-of-course assessments designed to assess proficiency in the subject areas of Algebra I, Algebra II, Geometry, Literature, English Composition, Biology, Chemistry, U.S. History, World History, and Civics and Government.

The Keystone Exams are one component of Pennsylvania's statewide high school graduation requirements. Keystone Exams will help school districts guide students toward meeting state standards.

TESTING WINDOW FOR THE KEYSTONE EXAMS 2019-2020	
Time of Year	Date
Winter Wave 1	December 2-13, 2019
Winter Wave 2	January 6-17, 2020
Spring	May 11-22, 2020
Summer	July 27-31, 2020

Extended School Year (ESY)

ESY services are special education and related services that are provided to students with disabilities beyond the 180-day school year. The Individuals with Disabilities Education Act (IDEA), the federal special education law, states that local education agencies

must provide ESY services if a student needs these to receive a free appropriate public education (FAPE). There are very specific criteria established by PDE which outline the parameters for school-based teams to review for student eligibility for ESY.

Important note regarding Extended School Year (ESY) – ESY and “Summer School” are NOT the same concept. ESY is a component of special education programming that is individually determined for students with disabilities. It is not intended a means for credit recovery and/or for retaking academic courses. There are specific eligibility parameters for the designation of ESY and must be reviewed and determined by a student’s IEP team, that are further explained in a later section of this manual. The following graphic outlines the important dates to note for students who may be eligible for ESY.

ISPA Student Conduct

ISPA implements disciplinary procedures consistent with the Pennsylvania Code and the Individuals with Disabilities Act. Student offenses dictate the consequence ISPA may impose. In addition to the specific offenses set forth below, ISPA is within its rights to discipline any student who engages in conduct that threatens the health, safety or welfare of others or disrupts the learning environment. The appropriate consequence will be determined at the sole discretion of the school in accordance with the law. Student rights regarding disciplinary procedures are outlined in the final section of this code. In all disciplinary situations parent and student will be notified by either ISPA's Executive Director, Academic Director, or Principal, and provided with an explanation of the action taken. Appeals can be made to ISPA's Chief Executive Officer (CEO) who will review the merits of case.

Discipline Procedures: A student cannot be suspended or expelled and thereby deprived of a free education provided in the public schools without due process. Due process requirements guarantee all students the right to fair notice, fair procedures and a fair hearing. The student and his or her parent or guardian have the responsibility to follow the procedures set forth below in a respectful and timely fashion. A student who is accused of misbehavior or a breach of this Code of Student Conduct will be addressed by the Executive Director or his/her designee (Academic Director, Principal).

Written referral: Violations shall be presented in written form and should be specific, indicating the breach of the Code of Student Conduct for which the referral is being issued.

Student notification: The student will be placed on notice of the violation by the Executive Director or appointed designee and afforded an opportunity to explain.

Initial conference: An initial conference (in person or by tele- or video- conference) shall be conducted by the Executive Director or appointed designee at each level of discipline.

Charges and Evidence: The Executive Director or appointed designee, shall confer with the student, explain the charges and evidence against the student and allow the student an opportunity to present his or her side of the story prior to taking disciplinary action.

Parental Assistance: A good faith effort shall be made by the Executive Director or appointed designee, to employ parental assistance or other alternative measures prior to suspension, except in the case of emergency or disruptive conditions that require immediate suspension or in the case of a serious breach of conduct.

1. **Parental notification: Telephone or Email:** The Executive Director or appointed designee shall attempt to speak with the parent by telephone and/or email to notify them of the student's misconduct and the next steps in the process for determining and implementing a proposed disciplinary action.
2. **By Written Notice:** Regardless of whether there has been communication with the student's parent by telephone or email, the Executive Director or appointed designee shall within twenty-four (24) hours of taking disciplinary action send written (hard copy) notice to the parent describing the disciplinary action imposed and the reasons action was taken.

Acceptable Use Policy

Insight PA Cyber Charter School is committed to student use of technology as a tool to expand learning opportunities and conduct scholarly research. The use of technology facilitates global collaboration- a vital skill for our 21st century learners. Students at Insight PA utilize laptop computers on a wireless network. Laptops are strictly for educational use consistent with the educational goals of Insight PA the Children's Internet Protection Act (CIPA) and the Protecting Children in the 21st Century Act. This Acceptable Use Policy is designed to give students and their families' clear and concise guidelines regarding the appropriate use of laptops. The underlying premise of this policy is that all members of the Insight PA community must uphold the values of honesty and integrity. The proper use of technology reflects the strength of one's character, as does one's behavior. We expect our students to exercise good judgment and to utilize technology with integrity.

Email

- Students should always use appropriate language in their e-mail messages.
- E-mail services provided by the School are to be used only for the exchange of appropriate information.
- No inappropriate e-mail is allowed including derogatory, obscene, or harassing messages. Email messages of an abusive or harassing nature will be regarded as a major violation and will be subject to a disciplinary response.
- Chain letters of any kind and span are prohibited. Chain letters are defined as any e-mail message asking you to pass information or messages on to other individuals or groups via e- mail.
- Students are prohibited from accessing anyone else's e-mail account without first receiving explicit permission from the account holder.
- E-mail etiquette should be observed. In general only messages that one would communicate to the recipient in person should be written.
- Only approved mail programs may be used for student mail.
- Only School-related attachments may be sent on the School e-mail system.

Games

- The School reserves the right to remove any game from a School computer that is considered inappropriate or impedes the educational purposes of the laptop program.
- The view and/or playing of electronic games is not permitted during School hours except as part of an assigned in-class activity.
- Games that include violence, adult content, inappropriate language and weapons are not to be installed or "played" on School computers including laptops.
- Screensavers that include gaming components are not allowed.

Laptops

- Student laptops must not be left unattended at any time. If a laptop is found to be unattended it will be turned in to the Technology Department.
- Laptops must be in a student's possession or secured at all times.

Hazing Policy

Insight PA is committed to maintaining a safe, positive environment for students and staff that is free from hazing. Hazing activities of any type are inconsistent with the educational goals of the school and are prohibited at all times.

Definitions

Hazing is defined by any action or situation which recklessly or intentionally endangers the mental or

physical health or safety of a person or which willfully destroys or removes public or private property for the purpose of initiation or admission into or affiliation with, or as a condition of continued membership in, any organization. The term shall include but not be limited to:

- Any brutality of a physical nature such as whipping, beating, branding.
- Forced calisthenics.
- Exposure to elements.
- Forced consumption of any food, liquor, drug or other substance.
- Any other forced physical activity which could adversely affect the physical health and safety of the individual, and shall include any activity which would subject the individual to extreme mental stress, such as sleep deprivation, forced exclusion from social contact, forced conduct which is intended to or could result in humiliation, extreme embarrassment, or any other forced activity which could adversely affect the mental health or dignity of the individual.
- Any willful destruction or removal of public or private property.

Authority

The School prohibits hazing in connection with any student activity or organization, regardless of whether the conduct occurs on or off school property or outside of school hours. No student, parent, guardian, coach, sponsor, volunteer or school employee shall engage in, condone or ignore any form of hazing. The School encourages students who have been subjected to hazing to promptly report such incidents to the Principal.

Delegation of Responsibility

Students, parents/guardians, coaches, sponsors, volunteers and School employees shall be alert to incidents of hazing and shall report such conduct to the Principal immediately. School administrators shall investigate promptly all complaints of hazing and administer appropriate discipline to any individual or student activity or organization found in violation of this policy.

For additional details pertaining ISPA policies and student codes of conduct, please refer to the Student and Parent Handbook, available for download on the [Insight PA website](#).

Attendance, Engagement & Family Involvement

The Insight Pa Cyber Charter School considers parents/guardians and/or designated Learning Coaches (LCs) as a vital part of the learning dynamic and encourages parents to not only take a collaborative role in their child's education but to be an active participant in the IEP process. The staff at Insight PA works to provide parents with the support and tools necessary to ensure that their student is successful in the virtual learning environment. With strong partnerships and regular communications, ISPA can maintain continuous awareness of the various ways our students are unique with their own set of contributions to offer society.

Depending on prior experience with computers and electronic communications, students and families often differ in the time it takes acclimation to the virtual learning model. The ISPA program, as assured through our state-issued charter, is vigorous and mastery-based by design. Yet specially customized trainings and live, staff-led support sessions are delivered as part of the orientation and onboarding framework for new students and their Learning Coaches. If a parent or guardian is struggling to support their student in this unique environment, ISPA staff will work with that parent to provide various strategies to assist them in providing the student the best learning environment.

Student Attendance Policy

In Pennsylvania, compulsory school age refers to the period of a child's life from the time the child enters school as a beginner, which may be no later than eight years of age, until the age of seventeen or graduation from a high school, whichever occurs first. In accordance with the Compulsory School Attendance Law and Pennsylvania State Code uniform rules have been adopted to ensure that students attend school regularly. Students are expected to attend school each day.

Pennsylvania requires all public schools to offer a minimum of one hundred and eighty (180) days of instruction between July 1 and June 30. Additionally, the statute requires all public schools to offer a minimum number of instructional hours by grade level:

Grade Level	Days	Minimum Yearly Hours	Daily Hours
K-6	180	900	5
7-12	180	990	5.5

Regular school attendance is an essential part of your student's education and vital to graduating ready to take on the demands of adult life. Students who are frequently absent may be putting their futures in jeopardy by falling behind in school. Chronic absenteeism is a behavior that is strongly associated with dropping out of school.

By establishing a daily routine for logging-in to the online school, completing course assignments in a timely manner and attending live class connect sessions, students will be able to successfully complete course and graduation requirements. Remember, communicating with teachers is the best way to stay on pace and ensure a successful online educational experience at ISPA. Students are required to follow the school calendar which includes 180 school days. **Attendance only occurs on school days as listed on the school calendar. Students can complete online work on holidays or weekends in order to maintain course progress, but no attendance credit will be awarded for work completed on non-school days.**

Attendance at Insight Pennsylvania

A student is counted as present for the day when he or she logs into the Online School through the student account, completes assignments within a course through the student account, attends a Class Connect Session accessed through his or her daily plan, or if necessary, when course attendance is logged by a Learning Coach.

Logging Attendance Insight Pennsylvania Systems will automatically capture daily Online School student log-in, course work, and class connect session attendance. In addition - Insight Pennsylvania requires that each Learning Coach log the time spent working on content in each course each day. Time entered here should reflect the total time spent working on the course that day (both online work in the Online School and off-line work completed by the student). For guidance on how to log attendance in the Online School please see the following video:

[How-to Video: Logging Student Attendance for Learning Coaches](#)

Learning Coach Responsibilities

Each ISPA family appoints a designated Learning Coach to support and/or guide their child's daily school routine. **The importance of the continuous involvement of Learning Coaches for students in all grades cannot be understated.** A Learning Coach is usually the student's parent or another responsible adult dedicated to making sure their child acclimates to the daily school schedule and program of supports, as it applies. The typical time commitment for a Learning Coach typically varies depending on the student and their grade level. Certain students who present with functional impairments or cognitive disabilities may require a Learning Coach to provide more direct observation of, and involvement with, the student as they utilize tools to navigate their educational program. **Learning Coaches who invest time and interest in learning the tools within the virtual learning platform, as well as the daily/weekly schedules for their ISPA students, generally experience better understanding**

of the school program and ways to continuously collaborate with ISPA to support their child more effectively in the academic program.

Additional needs for on-going engagement of students and families may also be required, for certain students who require multiple support and/or related services as required by the student's individualized education plan (IEP). are also extremely important, to allow for ISPA to access the student for the delivery of essential instructional supports or related service(s). Additional details regarding attendance for special education services are provided in the Related Services section of this manual.

As a general estimate, a Learning Coach can expect to spend the following amount of time:

- Grades K–5: 3 to 6 hours per day
- Grades 6–8: 2 to 4 hours per day
- Grades 9–12: 1 to 2 hours per day

Other Learning Coach responsibilities:

- Log progress and daily learning time
- Check student e-mail daily and communicate to teacher(s) as required
- Ensure students participate with their teacher(s) in any required direct instruction
- Submit student work samples or screenshots as needed
- Ensure that students participate in mandatory state and benchmark testing
- Ensure active internet connection availability
- Ensure student attends and participates in related service/therapy sessions, when the IEP requires related service(s)
- Utilize K12 Tech Support should any issue arise with a student laptop, impacting their ability to login

Student Responsibilities

- Log-on daily
- Complete lessons daily
- Attend and actively participate in Class Connect sessions (*live attendance may be mandated for attendance if the student is adequately engaged in their IEP program and/or not making expected progress*)
- Submit assignments on or before due dates; or by the allowable extension, if the IEP requires this accommodation
- Check emails daily and respond in a timely manner
- Communicate with therapists, evaluators, or other service providers, when applicable
- Attend and participate in related service/therapy sessions, when the IEP requires related service(s)

ISPA School Attendance Policies & Expectations

Based on Section 1723-A of the Charter School law, any resident grade K-12 school age student in the Commonwealth is eligible to enroll in Insight PA Cyber Charter School. Insight PA will not discriminate in admission policies or practices based on measures of intellectual ability, achievement or aptitude, sexual identity, gender expression, disability status, proficiency in English, or any other basis that would be illegal if used by a school district. We will not use achievement tests, entrance examination tests or other means of testing a student's intellectual ability to grant or deny admission. We will not judge a student's grade point average in consideration of any student enrollment.

As prospective families navigate through the process of enrolling their student(s) in Insight PA, they are asked a series of questions specific to each child, which provides ISPA with some important information about the student, their educational history, family unit and living situation, and the general factors which prompted the family to proceed with enrolling. ISPA does NOT use these responses in any way to determine acceptance or denial of a student for enrollment. The required components for affirming enrollment into Insight PA are in alignment with charter school regulations outlined by the PDE. For additional information regarding

the items required for enrollment readers are encouraged to review the Enrollment section of the [Insight PA Student & Parent Handbook](#))

School Attendance

The Insight PA Student and Parent Handbook contains the specific characteristics of what constitutes proper daily school attendance. Please note, all absences will be treated as **Unlawful (Unexcused)** until a parent or guardian submits a written explanation or medical excuse to Attendance@insightpa.org and copies Homeroom Teacher (K-5) or Advisor (6-10). If parents or guardians fail to submit a written explanation or medical excuse within three (3) days of the absence, the absence will be permanently counted as unlawful (unexcused).

One of the primary roles of Insight PA special education teacher is to advocate for the student when any barriers to the implementation of their IEP may arise, and patterns of absences are certainly seen as a significant barrier. If a student with a disability accumulates 3 unlawful absences, the ISPA Attendance Office will notify his or her assigned special education case manager. This notification should be of particular concern to both the school- and home-based teams supporting the student, as it poses a potential risk for the student's access to daily instruction and the implementation of the IEP.

Non-Discrimination Policy

Insight PA will not deny any student's admission to the school or deny participation in, deny benefits of or discriminate against any student in any curricular or extracurricular student services, recreational program or other program or activities. No student's rights shall be abridged or impaired because of their sex, race, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability as required by state and federal statutes. This policy also prohibits discrimination as defined by Title IX of the Education Amendments of 1972 (sex), Title VI of the Civil Rights Act of 1964 (race and national origin) and Section 504 of the Rehabilitation Act of 1973 (handicap).

Student Records Maintenance & Transfer

A student's permanent education record includes two types of information:

- official administrative records consisting of minimal identifying data, birth date, academic work completed, level of achievement as indicated by grades and standardized achievement test scores, and attendance data; and
- verified information of clear importance consisting of scores on standardized intelligence and aptitude tests, interest inventory results, health data, family background information, systematically gathered teacher or counselor ratings and observations and verified reports of serious or recurrent behavior patterns

A student's permanent education record does not include potentially useful information which has not been verified or shown to be clearly needed beyond the immediate present. Examples include such as things as legal or clinical findings and unevaluated reports of teachers and counselors which may be necessary in ongoing investigations and disciplinary or counseling actions. Information gathered by a non-school agency, such as a social caseworker report, also is not included in the student's record.

Confidentiality & Educational Privacy

Family Educational Rights and Privacy Act (FERPA)

Insight PA Cyber Charter School staff adheres to all portions of the Family Educational Rights and Privacy Act (FERPA) with regard to student educational records and personal information. FERPA affords parents and students over 18 years of age ("eligible student") certain rights with respect to the student's educational records. They are:

1. **The right to inspect and to review the student's educational records within 45 days of the date Insight PA receives a request for access** – Parents or eligible students will submit to the Insight PA CEO (or designated school official) a written request that identifies the records) they wish to inspect. The designee will arrange a records inspection for the parent or eligible student.

2. The right to request the amendment of the student's education records that the parent or eligible student believes is inaccurate or misleading

Parents or eligible students (age 18 and above) may ask Insight PA to amend a record that they believe is inaccurate or misleading. They should send an [email to the CEO](#), clearly identify the part of the record they want changed and specify why it is inaccurate or misleading.

If Insight PA decides not to amend the record as requested by the parent or eligible student, notice will be given to the parent or eligible student of the decision. Information will be given advising him or her of the right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be included to the parent or eligible student when they are notified of the right to a hearing.

3. The right to consent to disclosure of personal information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent

One exception, which permits disclosure without consent, is disclosure to school officials with legitimate educational interests. A school official is a person employed by Insight PA as an administrator, supervisor, instructor or support staff member (including health or medical staff and law enforcement unit personnel); a person serving on the Insight PA Charter School Board; a person or company with whom Insight PA has contracted to perform a special task (such as an attorney, auditor, medical consultant or therapist); or a parent or student serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks.

A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

Upon request, Insight PA will disclose education records without consent to officials of another school in which a student seeks or intends to enroll. (Note: FERPA requires a school district to make a reasonable attempt to notify the student of the records request unless it states in its annual notification that it intends to forward records on request.) Another exception involves student information designated as Directory Information. See above for the policy on disclosure of Directory Information.

Families have the right to file a complaint with the U.S. Department of Education concerning alleged failures by Insight PA to comply with the requirements of FERPA. The name and address of the Office that administers FERPA is: *Family Policy Compliance Office | U.S. Dept. of Ed. | 600 Independence Avenue, SW | Washington, DC 20202-4605*

Special Education Records

Incoming Transfer Records

As a new student is approved for enrollment with Insight PA, the School Registrar issues a Release of Records, signed by the parent or guardian, to the school reported to be the most recent school attended by the student. This document initiates the anticipated exchange of cumulative file documents for all enrolling students. ISPA has further customized this document to include the specification of certain Special Education Records that would be considered most essential for including in that request. The inclusion of this verbiage on ISPA's standard Release of Records template for every student allows for special education records to be released for students who may have not been indicated as requiring special education on the enrollment query for this item.

If and when this occurs, ISPA reviews all special education records received for essential information that would inform ISPA of the present status of special education eligibility, the recommended program of supports and services, as well as the determination of the Least Restrictive Environment (LRE); which is described as the *minimum* amount of time the IEP team believes the student should receive instruction outside of the general education curriculum or setting.

The student's status would be adjusted within the TotalView Enrollment (TVE) portal, so the student information system is able to capture and report the student for Child Find purposes. This is done by

ISPA Process: Incoming Records

During the Summer/Fall enrollment season, the Special Education Department will update the internal Special Education Enrollment Tracker daily; to ensure the department maintain regular updates of each student approved for enrollment also with a 'Yes' indicator on the prior special education history enrollment query. These updates may include confirmation of special education status or

Outgoing Records Transfer

A student's permanent record may be transferred only to specified individuals or entities:

“officials of other primary or secondary school systems in which the student intends to transfer, the state superintendent or his officials and subordinates consistent with the superintendent's statutory powers and responsibilities, and school officials and teachers who specifically indicate a legitimate educational interest.”

The school responsible for transferring a student's education record must inform parents of the transfer of the education record unless a parent requested the transfer, or the school policy includes notice that records will be transferred to another school in which the student intends to enroll. In addition, parents may receive, upon request, a copy of the education record and also must be provided an opportunity to seek to amend the education record.

Notification of Withdrawal

A family may express their intent to withdraw a student by calling the main administrative office or communicating their desire to their teacher. In each case, the office administrator or teacher will be instructed to capture all pertinent information on Insight PA's official Withdrawal Request Form. The school administrative staff or teacher will immediately send the family the School Withdrawal Form and Statement of Intent to Discontinue Education to be returned via mail, fax or email. The Homeroom Teacher or Advisor must complete a Withdrawal Report within three (3) days of notice of withdrawal.

In the event of any student withdrawal, for any reason, Insight PA will notify the district of residence within fifteen (15) days with a copy of the School Withdrawal Form and/or truancy letters if a student has accumulated too many unexcused absences with little or no attempt to resolve issues through a School Attendance Improvement Plan (SAIP). A copy of all withdrawal forms and district of residence notification will be kept in the student's file.

Maintenance of Educational Records

Insight PA maintains records concerning all children enrolled, including students with disabilities. Records containing personally identifiable information about or related to children with disabilities could include, but are not limited to, cumulative grade reports, discipline records, enrollment and attendance records, health records, individualized education programs, notices of recommended assignment, notices of intent to evaluate and to reevaluate, comprehensive evaluation reports, other evaluation reports by public school staff and by outside evaluators, work samples, test data, data entered into the Penn Data system, correspondence between school staff and home, instructional support team documents, referral data, memoranda and other education-related documents. Records may be maintained electronically, on paper, microfiche, audio and videotape. Records may be located in the central administrative offices of Insight PA, electronic storage systems and in the secure possession of teachers, school administrators, specialists, psychologists, counselors and other school staff with a legitimate educational interest in the information contained therein. All records will be maintained in the strictest confidentiality.

Records will be maintained as long as they remain educationally relevant and as otherwise required by applicable law. The purposes of collecting and maintaining records are to:

- Ensure that the child receives programs and services consistent with his or her IEP;
- Monitor the ongoing effectiveness of programming for the child;
- Document for the public school and the parents that the student is making meaningful progress;
- Satisfy the requirements of state and federal agencies who have an interest in inspecting or reviewing documents concerning particular students or groups of students for purposes of compliance monitoring, complaint investigation and fiscal and program audits; and
- Inform future programming for and evaluations of the child.

When educational records, other than those which must be maintained, are no longer educationally relevant, Insight PA will notify the parents in writing and may destroy the records or, at the request of parents/guardians, must destroy them. Insight PA is not required to destroy records that are no longer educationally relevant unless the parents request so in writing.

RESOURCE LINK: For additional information regarding the PDE guidance for Transfer of Records, click [here](#).

Special Education Guidelines

Insight PA Cyber Charter School operates under Chapter 711 regulations established for charter and cyber charter schools by PDE. When a child with an IEP transfers to a charter school or cyber charter school, the charter school or cyber charter school is responsible upon enrollment for ensuring that the child receives special education and related services in conformity with the IEP, either by adopting the existing IEP or by developing a new IEP for the child in accordance with the requirements of IDEA. The IEP of each student shall be implemented as soon as possible but no later than 10 school days after its completion.

Child Find

According to Chapter 22 PA Code §711.21, all charter and cyber charter school entities within the Commonwealth must establish written policies and procedures to ensure all children with disabilities who are enrolled in ISPA, and who are in need of special education and related services, are identified, located, and evaluated.

Special Education Query at Enrollment

As a newly enrolling family navigates through the web-based enrollment portal, a 'Yes' response to the question "Does your child have an IEP, or have they ever been evaluated for Special Education?" provides ISPA with initial notification of a student enrolling

who is believed to present with an educational disability. As various enrollment cohort dates approach, ISPA conducts daily or weekly reviews of any student approved for enrollment that is also indicated to require special education supports and/or services. The Special Education Department records assistant begins efforts to request specific updated documents that

Identification & Eligibility

Before a student can receive special education services, ISPA must establish that the student meets eligibility criteria as a child with an educational disability under IDEA.

RESOURCE LINK: The definitions of each educational disability category may be reviewed by selecting this [link](#).

Parents and legal guardians seeking to enroll a school-age student into Insight PA is presented with a series of questions within the online registration portal. This adaptive-response system queries families to notify the school of additional information that would particular responses to Child Find-linked item. students Child find questions are completed by the parent within the online enrollment portal. These questions are asked again by the Personal Admissions Liaison (PAL) during the enrollment approval and placement process.

Once the school year begins, all staff will be trained on child find responsibilities and procedures, then the assigned staff member will again conduct a probe to determine if the student has any academic needs.

Any student for whom a parent answers that they previously or are currently receiving special education services is immediately referred to the Special Education Manager or designee.

Any special education or evaluation records shared by the parent with the assigned homeroom teacher are forwarded to the special education department at specialrecords@k12.com so that they can be reviewed by the school psychologist and/or Special Education Manager or designee to determine next steps.

Least Restrictive Environment (LRE)

Insight PA is responsible for making sure that students with disabilities are educated alongside students without disabilities to the extent appropriate for the student. Generally, “appropriate” means that the education meets the student’s special needs and allows the student to make educational progress. The general education classroom is the first placement choice the Individualized Education Program (IEP); however, it is not always considered the “least restrictive” setting for students with disabilities to receive all of their instructional programming. Each student’s IEP team reviews all available data reflecting that student’s strengths, needs, and conditions under which the student experiences the most success. From there, the recommendations for specially designed instruction in time, setting, and/or delivery format is written into the IEP as it relates to the individual student.

To accomplish the delivery of special education programs and services in the LRE, ISPA is required to ensure (1) that the placement be determined by the child's IEP team; (2) that a continuum of placement alternatives be discussed; and (3) that a child with a disability be provided with instruction in a setting different from that of non-disabled peers ONLY when the nature or severity of the child’s disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

In addition to regular and special education classrooms, the continuum of placement alternatives the IEP team can consider include public or private institutions or other care facilities. Chapter 711 of Title 22 of the Pennsylvania School Code describe a wide variety of special education service and placement options which may, as determined by the IEP team, be pursued by ISPA in the event it established the student’s needs exceed that which can be reasonably met within the continuum of supports ISPA has established. In summary, special education programs and services that specified in the regulations may be provided directly by ISPA or, when absolutely necessary and/or mutually agreed upon, through an arrangement with another public agency or private organization.

Special Education Continuum of Services

Since students with disabilities require differing amounts and types of specially designed instruction and/or services, ISPA must adopt a range of placement options, referred to as a 'continuum of special education services.' This allows IEP teams to ensure gradual changes are aligned with students according to the trends in their performance and growth. IDEA regulations at 34 CFR § 300.115 specify "that:

- A. Each public agency is to ensure that a continuum of alternative placements is available to meet the needs of children with disabilities for special education and related services.
- B. The continuum required in paragraph (a) of this section must—
 1. Include the alternative placements listed in the definition of special education under §300.38 (instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions); and
 2. Make provisions for supplementary services (such as a resource room or itinerant instruction) to be provided in conjunction with regular class placement." Parent/Legal Guardian (LG) Participation in IEP Meetings

Educational Placement

The IEP team that determines the educational placement for a student with a disability must include individuals with specific expertise or knowledge. Although the parents of the student are part of the IEP team determining the student's placement and are likely to be well informed as to the placement decision, ISPA must still provide parents with prior written notice about the placement decision a reasonable time before it implements that decision as outlined in 34 CFR § 300.503.

To this end, ISPA must ensure that:

- A. The placement decision –
 - 1) Is made by a group of persons, including the parent, and other persons knowledgeable about the student, the meaning of the evaluation data, and the placement options, and
 - 2) Is made in conformity with LRE provisions of this subpart, including §§300.114 through 300.118;
- B. The student's placement –
 - 1) Is determined at least annually;
 - 2) Is based on the child's IEP; and
 - 3) Is as close as possible to the child's home
- C. Unless the IEP of a child with a disability requires some other arrangement, the child is educated in the school that he or she would attend if nondisabled;
- D. In selecting the LRE, consideration is given to any harmful effect on the child or on the quality of services that he or she needs; and
- E. A student with a disability is not removed from education in age-appropriate general education classrooms solely because of needed modifications in the general education curriculum

The IEP team may not refuse to place a student in a general education classroom because:

- the student cannot do the same work at the same level as the other students in the regular education class if the student can make meaningful progress on the goals in their IEP in a regular education class;
- the placement would be more expensive or inconvenient to the school;
- the student has a certain type of disability or because the disability is severe in the school's view (for example, a school cannot have a policy that places all students with autism in an autistic support classroom);
- there is no room in the regular classroom for more students, but there is room in the special education classroom; and/or
- the curriculum used in that classroom has to be modified for the student because of their disability

Age Range

When the student is participating in a special education class or service at ISPA, PDE guidance is that the other students in their class must be near their age. The maximum age range allowed in classrooms serving students with disabilities is three years for grades K-6, and four years for grades 7-12 (22 PA Code § 14.146). **The IEP team can decide that an exception to this rule is appropriate for a particular student, but it must explain in the IEP why it made an exception to this guideline for the student.**

Cyclical Monitoring for Continuous Improvement (CMCI)

The Bureau of Special Education (BSE) provides technical assistance, training, and monitoring activities to assist ISPA with implementing LRE requirements. In adherence to 34 CFR § 300.119, the BSE must carry out activities to ensure that teachers and administrators in all public agencies –

- A. Are fully informed about their responsibilities for implementing § 300.114; and
- B. Are provided with technical assistance and training necessary to assist them in this effort.

PDE will continue to conduct a series of activities regarding least restrictive environment requirements of IDEA 2004. These activities will include (1) monitoring LRE requirements, (2) professional development for school personnel, (3) clarification on the use of supplementary aids and services in the regular classroom, and (4) building the capacity of all public schools to provide such aids and services.

To this end, the Bureau of Special Education (BSE) conducts comprehensive monitoring of local special education programs throughout the commonwealth of PA. Under the CMCI system, local education agencies engage actively in the monitoring process, from participating in pre-monitoring training, through self-assessment, on-site collaboration with the BSE team, corrective action planning and implementation.

General Schedule for CMCI Procedures:

Timeframe	Activity	Participants
Pre-On-site	60 days prior to on-site visit the list of students for whom LEA must complete the FSA #23 Educational Benefit Review is mailed to the LEA. 30 days prior to on-site visit LEA submits the entire FSA, via the web, to Leader Services.	
On-site Day 1	Entrance conference and Administrative Interview (Review/discussion of information submitted in the FSA) File Reviews (In-depth student case studies including classroom observations)	<ul style="list-style-type: none"> • Superintendent/CEO • Director/Supervisor/Coordinator of Special Education • Representative Building Principals • School Psychologists • Others as designated by the Superintendent/CEO or PDE Team • PDE Monitoring Team <ul style="list-style-type: none"> • Building Principals • Teachers – Special and General Education • Parents • PDE Monitoring Team
On-site Day 2	Continuation of File Reviews Meeting of the Chairperson and peers to review data from on-site. Forward any required documentation and forms to the Chairperson.	<ul style="list-style-type: none"> • Chairperson • Peers
On-site Day 3 (½ day)	Exit Conference	<ul style="list-style-type: none"> • District Superintendent/CEO • Director/Supervisor/Coordinator of Special Education • Other designated personnel • PDE Monitoring Chairperson

Corrective Action Plan for Continuous Improvement

The most recent CMCI review by the BSE conducted for Insight PA was completed the week of April 8th of the 2018-2019 school year. As a result of the CMCI process conducted at ISPA, the BSE will generate a report of its findings along with a detailed Corrective Action Plan (CAP) within 60 days. The CAP will outline all specified areas which ISPA must correct no later than 180 days (or one school year) from issuance of BSE’s final monitoring report.

For certain types of findings, corrective action will be prescribed, and will not vary from school to school. For example, if the finding is that the school lacks a specific required policy, it is reasonable to have the BSE prescribe a standardized remedy and timeline for correcting this deficiency. However, the school, based on its unique circumstances and goals, will individually design the majority of corrective action strategies to be implemented once approved by PDE.

Support for School Personnel

ISPA is a member of the Chester County Intermediate Unit (CCIU) Consortium, which provides our personnel with access to comprehensive resources and professional development opportunities. Furthermore, ISPA staff participate in trainings hosted either face-to-face or via webinar by Educational Consultants of the PA Training and Technical Assistance Network (PaTTAN). PaTTAN educational consultants participate in the development of the Compliance Plan for Corrective Action. PaTTAN and IU Consultants forward documentation to ISPA as assigned in the agreed upon Compliance Plan for Corrective Action.

ISPA personnel, specifically the Director of Special Education Compliance and/or the Special Education Compliance Coordinator, will maintain contact with the BSE Single Point of Contact (SPOC) to submit and verify completion of each corrective action item required within the 180 day correction window.

The SPOC maintains overall responsibility for documenting implementation of the Compliance Plan for Corrective Action. However, PaTTAN staff will support ISPA in corrective action verification in a variety of ways, (e.g., *providing technical assistance to improve LEA file reviews, collecting and reviewing required documents, providing and verifying required training as outlined in the Plan*). All activity is documented via a template that is available electronically, so that tracking can occur and be maintained by the BSE.

RESOURCE LINK: Additional information and resources regarding the CMCI process may be found at the following [link](#).

Procedural Safeguards

The Procedural Safeguards Notice describes the rights of a parent of a child with a disability and the procedures that safeguard those rights under state and federal special education law, including the Individuals with Disabilities Education Act, commonly referred to as "IDEA 2004". These laws and regulations require schools to provide a free appropriate public education (FAPE) to all students with disabilities who are in need of special education. A free appropriate public education, or FAPE, means special education and related services designed to meet the individual educational needs of your child are provided, at no cost to you, in conformity with your child's Individualized Education Program (IEP).

The contents of the Procedural Safeguards Notice will include details regarding the rights and regulations including:

Authority of Parents and/or Surrogate Parents for Educational Decision-Making

A parent is a biological or adoptive parents of a child; a foster parent; a guardian generally authorized to act as the child's parent, or authorized to make educational decision for the child; an individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or a surrogate parent.

A surrogate parent must be appointed when no parent can be identified; the public agency, after reasonable efforts, cannot locate a parents; the child is a ward of the State under the laws of Pennsylvania, or the child in an unaccompanied homeless youth as defined by the McKinney-Vento Homeless Assistance Act, 42 U.S.C. Sec. 11434a(6).

Additional information regarding the regulations for appointing a Surrogate Parent is outlined in a later section of this manual.

Prior Written Notice

ISPA must notify parents/guardians in writing whenever it involves certain events or proposed options, including, but not limited to:

- a) Proposes to initiate or to change the identification, evaluation, or educational placement of your child, or the provision of a free appropriate public education (FAPE) to your child; or

- b) Refuses to initiate or to change the identification, evaluation, or educational placement of your child, or the provision of FAPE to your child.
- c) Change of placement for disciplinary reasons.
- d) Due process hearing, or an expedited due process hearing, initiated by LEA.
- e) Refusal of LEA to agree to an independent educational evaluation (IEE) at public expense.
- f) Parents' revocation of consent for special education and related services.

In Pennsylvania, prior written notice is provided by means of a document entitled "Prior Written Notice Form/Notice of Recommended Educational Placement (PWN/NOREP)." Parents should be given reasonable notice of this proposal or refusal so that if they do not agree with ISPA, they may take appropriate action to respond via the Parental Consent section of the PWN/NOREP document. Reasonable Notice means ten days; after which point, ISPA may proceed with its proposed action as it relates to the its obligation to implement FAPE for the particular student.

Independent Educational Evaluation:

When ISPA completes its evaluation, the parent may request an independent educational evaluation (IEE) if it finds disagreement with ISPA's findings. When this occurs, ISPA must issue Prior Written Notice to inform the parent of its decision on providing the IEE at public (ISPA) expense. Once agreement is established, ISPA must provide its criteria and a list of approved professionals to provide the evaluation. The professional designated to conduct the IEE must not be employed by, contracted with, or in any way personally associated with ISPA; thus establishing the "independent" nature intended for this particular evaluation. It allows for a differing, objective review of the student, their educational and/or functional needs, as well as proposed eligibility criteria.

If an IEE is conducted with ISPA's knowledge and involvement, the completed IEE report must be reviewed by ISPA and considered against its recommendations for FAPE, for the IEP team to consider what, if any, modifications to the educational program or continuum of supports would be reasonably appropriate in order to ensure the student can achieve educational progress.

Complaint and Mediation Resources

Parents have the right to complain to the state, usually the state compliance office in the department of education of that state. The safeguards provide guidance as to how this happens. The state will also provide mediation in disputes between parents/guardians and the school district (LEA.)

Due Process

This is the procedure to change the IEP in any way, whether it is for services (speech, physical therapy, occupational therapy,) a change in placement, even a change in diagnosis. Once a parent starts the process, the old IEP stays in place until a decision is rendered.

For additional information regarding formal complaints to the Department of Education, please consult with the section of this manual entitled, "[Special Education Grievances & Dispute Resolution.](#)"

Manifestation Determination

This describes how students with disabilities will be handled in the disciplinary process for significant behaviors, such as fighting, disrupting the class, etc. A meeting must be held when a student has been suspended ten days to decide if that behavior is related to his or her disability.

Alternative Placement

This describes how parents can voluntarily choose to remove a child from the public school and seek instruction in an alternate setting. It also describes the circumstances under which Insight PA will be required to pay for that placement.

RESOURCE LINK: To access the official Procedural Safeguards Notice for Pennsylvania, click [here](#). An audio recording of the Procedural Safeguards Notice may be obtained at the following [link](#).

Surrogate Parents for Educational Decision-Making

The Individuals with Disabilities Education Act (IDEA), as amended in 2004, mandates procedures that protect the rights of a child whenever the parents of a child are unknown. The LEA must assign an individual to act as a surrogate for the parents and authorize this individual to make educational decisions relating to the provision of special education services for a child.

The LEA is required to assign a surrogate parent whenever: 1) a birth or adoptive parent is unknown or cannot be located; 2) parental rights to make educational decision have been limited or terminated, and there is no foster parent, guardian, or other individual acting in the place of a parent with whom the child lives; or 3) the child is an unaccompanied homeless youth. To fulfill this obligation, the LEA must develop a method for identifying any child who needs a surrogate parent and must assign a surrogate parent within 30 calendar days of determining that a surrogate parent is required.

A parent (now referred to as an IDEA parent) is defined under IDEA as:

- A biological or adoptive parent of a child;
- A foster parent;
- A guardian authorized to act as the child's parent, or authorized by a court to make educational decisions for the child (Note: with limited exceptions as discussed in the Special Circumstances Section of this Base Education Circular, this does not include a representative of a child welfare agency);
- An individual acting as a parent in the place of the biological or adoptive parent with whom the child lives (including a grandparent, stepparent, or other relative) or a person who is legally responsible for the child's welfare); or
- A surrogate parent who has been appointed by an educational agency or an educational decision maker appointed by a court in accordance with IDEA. (Note: Apart from two limited exceptions as discussed in the Special Circumstances Section of this Basic Educational Circular, federal law prohibits anyone employed by an agency that is involved in the care or education of the child from serving as a surrogate parent.)

Whenever a birth or adoptive parent has retained legal rights to make educational decisions and is contacting the LEA to act as the parent on behalf of his/her child in the special education process, ISPA must treat the birth or adoptive parent as the educational decision maker. However, whenever a court order specifies an individual as the educational decision maker, the school must treat that person as the only person authorized to make special education decisions for the child.

LEA Procedure

If a student enrolls with ISPA with no legal or educational guardian appointed, or if the absence of one becomes known at any point during their active enrollment period, ISPA must ensure that a surrogate parent is appointed to represent the child in all matters related to identification, evaluation, placement, and the provision of FAPE. These conditions are formally described as:

- No IDEA parent can be identified;
- The local educational agency, after reasonable efforts, cannot locate a parent;
- The child is a ward of the State as defined by State law (Pennsylvania does not have a state law definition of ward of the State so this provision does not apply in Pennsylvania); or
- The child is an unaccompanied homeless youth as defined in §725(6) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434(a)(6)) (i.e., youth who lack a fixed nighttime residence and are not in the care of a parent or guardian).

In the absence of any IDEA parent or a person appointed by a court, it is the legal obligation of the LEA to appoint a surrogate parent. All LEAs are encouraged by PDE to collaborate with child welfare agencies and to coordinate

efforts to identify and appoint surrogate parents without delay. ISPA is required to comply with this regulation for appointing a Surrogate Parent within a 30-calendar day timeline.

Selecting a Surrogate Parent

A surrogate parent may be a relative of the child, a prior foster parent, a person who knows the child, a Court Appointed Special Advocate, or a Guardian ad Litem also known as a child advocate. If there is no one in the child's life who is willing or able to serve in this role, another individual must be appointed to be the surrogate parent for special education matters. All surrogate parents must have the knowledge and skills necessary to serve the best interests of the child.

A surrogate parent may not be an employee of a child welfare agency (including a case manager, an employee of a private child welfare agency with whom a public agency contracts, a group home parent, or staff in a residential facility), or an employee of an educational agency that is involved with the child (such as the child's teacher, a board member, or a school district employee). In addition, a surrogate parent appointed by the LEA must not have a personal or professional interest that conflicts with the interest of the child the surrogate parent represents.

The Surrogate Parent's Role

A surrogate parent stands in the place of the parent and can make all of the special education decisions that are usually made by the biological or adoptive parent. For example, surrogate parents may review a child's educational records, request and/or consent to evaluations and re-evaluations, approve or disapprove of Individualized Education Programs (IEPs) and changes in educational placement, and disagree or dispute the recommendations of the local educational agency by asking for mediation or by requesting a due process hearing. A surrogate parent under IDEA does not have any rights outside of the special education system unless awarded by a court.

Special Education Eligibility Determination

Special education services are provided according to the primary educational needs of the child, not the category of disability. The types of service available are (1) learning support, for students who primarily need assistance with the acquisition of academic skills, (2) life skills support, for students who primarily need assistance with development of skills for independent living, (3) emotional support, for students who primarily need assistance with social or emotional development, (4) deaf or hearing impaired support, for students who primarily need assistance with compensatory skills to address deafness, (5) blind or visually impaired support, for students who primarily need assistance with compensatory skills to address blindness, (6) physical support, for students who primarily require physical assistance in the learning environment, (7) autistic support, for students who primarily need assistance in the areas affected by autism spectrum disorders, and (8) multiple disabilities support, for student who primarily need assistance in multiple areas affected by their disabilities.

Related services are designed to enable the child to participate in or access his or her program of special education. Examples of related services are speech and language therapy, occupational therapy, physical therapy, nursing services, audiologist services, counseling, and family training.

Multidisciplinary Student Evaluation

The multidisciplinary evaluation process is a formal process with regulated timelines, when the school issues & then receives a signed Parental Consent for Initial Evaluation or Re-evaluation document outlining the procedures the school plans to conduct in order to determine perform a full evaluation of one or more suspected educational disability.

At ISPA, our evaluation procedure requires significant involvement and ongoing responsiveness of our families in order to coordinate the assessment procedures in person with the assigned evaluator(s). Additionally, most of our qualified evaluating

professionals are contracted for evaluation assignment according to evaluation type(s) needed, as well as geographical location of the student.

Initial Evaluation Process & Timelines

Psychoeducational Evaluations – When a request for an evaluation of a student is received, the individual receiving this notice must inform the School Psychology Department within one (1) school day. This communication is sent through ISPA's [19-20 Special Education Evaluation Request Form](#). In order to provide a response to this request, the assigned grade-band School Psychologist will review the reason for referral, consult with the parent/guardian, and issue a Prior Written Notice Evaluation Consent form to obtain informed consent, OR a Notice of Recommended Educational Placement to document any reasons for which ISPA would refuse to evaluation at the given time of the request. When an evaluation is determined necessary and consent is received, the school psychologist will provide the Related Services Coordinator (RSC) the types of assessment procedures the evaluation will require. Additional important factors pertaining to ISPA student evaluations are as follows:

- All psychoeducational evaluation reports (ER) and reevaluation reports (RR) must be completed on the PDE format – [School Age ER Template](#) or [School Age RR Template](#)
- All contracted evaluation reports received must be completed and received by ISPA within 45 calendar days of the referral date
- All contracted evaluation reports are routinely reviewed internally for compliance with the assessments requested and the proposed determination of disability and/or service eligibility
- All assessments must be provided and administered in the child's native language

Please find below the updated procedures and required information for evaluators. These updates are intended to assist Insight PA Cyber Charter (ISPA) in providing comprehensive, legally defensible psychoeducational evaluations and link the data to supports and services. Evaluators with specific questions regarding the provision of the specified information may contact ISPA School Psychologist Tony Grande through email (agrande@k12.com) or phone (484-713-4353, EXT 3092). Additionally, you may wish to contact ISPA School Psychologist Ranelle Hartley or Tony Grande for specific, case related questions.

Contact Information School Psychologists:

Grade-Bands K-7: Ranelle Hartley (rhartley@insightpa.org)

Grade-Bands 8-12: Tony Grande (agrande@k12.com)

I. General Procedures

- a. Evaluators should complete ALL requested assessments, subtests, rating scales, observations, and/or any specifically assigned data collection procedures outlined on the parental right to evaluate/reevaluate (PTE/PTR). The evaluation process will not be deemed complete until all specified data are collected.
- b. ISPA may request additional information based on the findings provided from the original data collection process as a component of a comprehensive psychoeducational evaluation.
- c. Evaluators should conduct additional assessments and/or rating scales in accordance with the results that warrant further data collection. Evaluations that include areas of concern that are not fully investigated will not be accepted as complete. (e.g., students with Global composite of <75 should include a parental rating scale for adaptive functioning).

- d. Evaluators will provide summaries to findings based on all the data collected. It should be noted that all final eligibility decisions are made by ISPA, acting as the Local Education Agency (LEA). Furthermore, all reports are reviewed with parents by ISPA.

II. Observation Procedures

- a. Each evaluation may include an observation of a student during a live session class. These observations should include the following:
 - i. Qualitative discussions of the learning environment, class observed, activities completed, and behaviors observed.
 - ii. Quantitative data for behaviors (e.g., frequency, momentary time sampling, etc.).

III. Assessment/Rating Scale Procedures

- a. Evaluators completing ability testing (IQ) should collect and include the alternative collective process scores (e.g., WJ-IV-Cog—Gf/Gc; WISC-V—GAI) in the written evaluations.
- b. All assessments should include a qualitative description of the testing environment, the student's observed behaviors, response style, and other information deemed appropriate by the evaluator.
- c. All assessment and rating scales should include charts with Standard Scores/Scaled Scores/T-Scores, and qualitative descriptors (please see sample reports for possible templates).
- d. For broad/narrow-band cognitive and achievement measures, a brief description of the subtests should be provided that explains the task(s), a qualitative summary of the student's behaviors, their performance, and what this performance means to overall cognitive ability/academic skill development. Please see sample report as a guide.
- e. Noted academic skill-deficits should be discussed in relation to measured cognitive abilities when applicable. Please consult the sample reports as a guide.
- f. For students who have been retained, age and grade-based norms should be included if deemed appropriate.

IV. Specific Learning Disability Identification

- a. ISPA utilizes a significant ability-achievement discrepancy procedure to determine SLD eligibility. ISPA may request both broad and narrow band assessments in order to further understand the student's overall ability/achievement profile and provide legally defensible evaluations.
- b. ISPA recommends utilizing co-normed cognitive and achievement assessments (e.g., WISC-V/WIAT-III; WJ-IV-Cog/WJ-IV-Ach) to determine the base-rates (Weschler) or predicted vs. actual scores (Woodcock-Johnson).
- c. Please find our policy regarding discrepancy analyses for the co-normed assessments. Please note that clinical interpretation is always necessitated, but we do wish to provide a standardized procedure.
 - i. WISC-V/WIAT-III: $\leq .10$ or below for base rate
 - ii. WJ-IV-COG/WJ-IV-ACH: Actual vs. predicted scores with a statistically significant discrepancy of 1.5 SD (i.e., 22.5 Standard Score points).
 - iii. An exceptionality to the discrepancy procedures outlined would be if there is significant statistical scatter (approx. 1 SD/15 points) amongst composites/indices which results in an overall reduced Global/Supplementary score. This may necessitate clinical interpretation, but it should be noted that ISPA maintains the right to alter the conclusion.
- d. If utilizing a non-co-normed assessment battery, practitioners should send raw scores to Ranelle Hartley (regardless of grade) so they may be run through the X-Bass system.
- e. Conclusions regarding SLD determination should be interpreted utilizing an ecologically-valid model. This means that environmental, medical, attentional, and clinical factors should be thoroughly discussed in relation to this determination.
- f. Exclusionary factors for SLD identification should include instructional factors, vision, hearing, motoric functioning, cognitive and adaptive functioning, social-emotional and psychological factors, environmental and economic factors, cultural or linguistic factors, and/or physical and health factors. For further information, please see appendix A. (Alfonso & Flanagan, 2018) (pgs. 343-347). All of the aforementioned criteria should be addressed within the report.

Additional evaluation components may be requested by ISPA. If the assigned evaluator experiences any barriers or anticipates any delays to the timely completion of the student evaluation, they are advised to communicate with ISPA Related Services Coordinator, who serves as the liaison between our contracted professional personnel and our School Psychology Department.

UNDER NO CIRCUMSTANCES should an evaluation be completed without a signed *Permission to Evaluate* form; unless explicitly requested by ISPA, in which case the assigned evaluator would be asked to bring the unsigned consent form to the scheduled evaluation session to obtain the required signature.

Upon receipt of an evaluation ISPA will review to ensure all required components are present prior to accepting the evaluation as completed. If components specifically requested are missing from the evaluation, ISPA reserves the right to send it back to the evaluator to complete the evaluation as expected at no additional cost to the school.

Initial Evaluation Timelines

<h2>Evaluation</h2>		
Action	Timeline	
	School Days	Calendar Days
When a parent orally requests an evaluation, the local educational agency (LEA) must provide a copy of the <i>Permission to Evaluate-Evaluation Request</i> form to the parent.		10
When a parent presents a written request for an evaluation, if the LEA agrees to evaluate as requested, the LEA must provide the <i>Permission to Evaluate-Consent</i> form and <i>Notice of Recommended Educational Placement/Prior Written Notice (NOREP/PWN)</i> form to the parent.		Within a reasonable amount of time, generally considered to be 10
After the LEA receives written parental consent, the initial evaluation must be completed and a copy of the <i>Evaluation Report</i> presented to the parent.		60*
The parent must receive a copy of the <i>Evaluation Report</i> prior to the Individualized Education Program (IEP) meeting (unless a waiver is signed).	At least 10	

Re-Evaluation Timelines

Reevaluation		
Action	Timeline	
	School Days	Calendar Days
When a parent orally requests an evaluation, the local educational agency (LEA) must provide a copy of the <i>Permission to Evaluate-Evaluation Request</i> form to the parent.		10
When a parent presents a written request for an evaluation, if the LEA agrees to evaluate as requested, the LEA must provide the <i>Permission to Evaluate-Consent</i> form and <i>Notice of Recommended Educational Placement/Prior Written Notice (NOREP/PWN)</i> form to the parent.		Within a reasonable amount of time
As a result of the review of data, if additional data are required to determine continued eligibility and need for special education services, the LEA must issue the <i>Permission to Reevaluate-Consent</i> form.		Within a reasonable amount of time
After the LEA receives written parental consent, the reevaluation must be completed and a copy of the <i>Reevaluation Report</i> presented to the parent.		60*
The parent must receive a copy of the <i>Reevaluation Report</i> prior to the Individualized Education Program (IEP) Meeting (unless a waiver is signed).	At least 10	

Mandatory PA State Testing

Children with disabilities are included in general state and district-wide assessment programs, with appropriate accommodations, where necessary [Sec. 612 (a) (16) (A)]. The term “individualized education program” or “IEP” means a written statement for each child with a disability that is developed, reviewed, and revised in accordance with this section and that includes . . . a statement of any individual modifications in the administration of state or district-wide assessments of student achievement that are needed in order for the child to participate in such assessment; and if the IEP Team determines that the child will not participate in a particular state or district-wide assessment of student achievement (or part of such an assessment), a statement of why that assessment is not appropriate for the child; and how the child will be assessed. ([PDE resource link](#))

The Pennsylvania state assessment system is composed of assessments and the reporting associated with the results of those assessments. The specific assessments ISPA is mandated to coordinate and administer are the Pennsylvania System of School Assessment (PSSA), the Pennsylvania Alternate System of Assessment (PASA), and the Keystone Exams. A description for each will follow this section.

With the focus of legislation aimed at accountability and the inclusion of all students comes the drive to ensure equal access to grade-level content standards. Academic content standards are educational targets outlining what students are expected to learn at each grade level. Teachers ensure that students work toward grade-level content standards by using a range of instructional strategies based on the varied strengths and needs of students. For students with disabilities, accommodations are provided during instruction and assessments to help promote equal access to grade-level content. To accomplish this goal of equal access,

- every Individualized Education Program (IEP) team member must be familiar with content standards and accountability systems at the state and district levels;
- every IEP team member must know where to locate standards and updates; and
- collaboration between general and special educators must occur for successful student access.

All students with disabilities can work toward grade-level academic content standards and most of these students will be able to achieve these standards when the following three conditions are met:

1. Instruction is provided by teachers who are qualified to teach in the content areas addressed by state standards and who know how to differentiate instruction for diverse learners.
2. IEPs for students with disabilities are developed to ensure the provision of specialized instruction.
3. Appropriate accommodations are provided to help students access grade-level content.

PA State System of Assessment (PSSA)

Pennsylvania System of School Assessment (PSSA) includes assessments in English Language Arts and Mathematics which are taken by students in grades 3, 4, 5, 6, 7 and 8. Students in grades 4 and 8 are administered the Science PSSA. The English Language Arts and Mathematics PSSAs include items that are consistent with the Assessment Anchors/Eligible Content aligned to the Pennsylvania Core Standards in English Language Arts and Mathematics. The Science PSSA includes items that are aligned to the Assessment Anchors/Eligible Content aligned to the Pennsylvania Academic Standards for Science, Technology, Environment and Ecology.

The annual Pennsylvania System School Assessment is a standards-based, criterion-referenced assessment which provides students, parents, educators and citizens with an understanding of student and school performance related to the attainment of proficiency of the academic standards. These standards in English Language Arts, Mathematics, and Science and Technology identify what a student should know and be able to do at varying grade levels. School districts possess the freedom to design curriculum and instruction to ensure that students meet or exceed the standards' expectations.

Keystone Exams

Keystone Exams are end-of-course assessments in designated content areas. The Keystone Exams serve two purposes: (1) high school accountability assessments for federal and state purposes, and (2) a component of the statewide high school graduation requirement for students beginning with the class of 2022. The Algebra I and Literature Keystone Exams include items written to the Assessment Anchors/Eligible Content aligned to the Pennsylvania Core Standards in Mathematics and English Language Arts. The Biology Keystone Exam includes items written to the Assessment Anchor/Eligible Content aligned to the enhanced Pennsylvania Academic Standards for Science.

PA Alternate System of Assessment (PASA)

Pennsylvania Alternate System of Assessment (PASA) is a statewide alternate assessment designed for students with the most significant cognitive disabilities. Specifically, it is intended for those who are unable to participate meaningfully in the Pennsylvania System of School Assessment (PSSA) even with accommodations. By administering the PASA to students with severe disabilities, schools achieve compliance with federal laws and the Pennsylvania School Code that require that all students participate in the statewide accountability system.

The PASA is an individually administered test given each spring to students by their teacher or another certified Test Administrator who knows the student well. Test administration can be adapted so that even students with the most severe disabilities can participate in the assessment and receive a score. The test, administered to students in the equivalent of grades 3 through 8 and 11, consists of 25 test items aligned with reading standards; 25 test items aligned with math standards; and, for students in grades 4, 8, and 11, approximately 25 test items aligned with science standards. Each test item represents an authentic, relevant, and age-appropriate skill related to reading, mathematics, or science. There are three levels of difficulty within each grade for all three content areas. Level A contains the least complex reading-, math-, or science-related skills. Level B consists of intermediate skills, and Level C consists of the most complex skills. Like the PSSA, the PASA is designed to take a snapshot of student's typical performance on a small sample of academic skills derived from the PA Academic Standards.

Student performance is video recorded and submitted for scoring to the contractor at the University of Pittsburgh. Teams of scorers (comprised of practicing teachers, administrative school personnel, and college/university faculty) are trained to use a scoring rubric to evaluate student performance. Once scoring has been completed, aggregated results are submitted to the state for

inclusion with scores from the PSSA. In addition, PASA reports are generated at the state, home district, service provider, and student levels.

For additional information regarding the PASA, please see the following [link](#).

PASA Eligibility Criteria

The PASA Eligibility Criteria: Decision Making Companion Tool is a resource provided to individualized education program (IEP) teams in Pennsylvania to assist in determining eligibility for the Pennsylvania Alternate System of Assessment (PASA). The PASA is appropriate for students with the most significant cognitive disabilities who meet all six requirements listed below. Additional considerations are provided that further define the criteria and assist the IEP team in decision making. Factors that the IEP team should not consider in eligibility determination are also identified.

The IEP team must answer “YES” to all six criteria in order for the student to participate in the PASA. If the answer is “NO” to any of the questions, the student must participate in the PSSA/Keystones with or without accommodations, as determined appropriate by the IEP team.

Please see the following page for a graphic outline of the criteria ISPA follows when making a determination regarding a student’s eligibility for the PASA.



**PASA Eligibility Criteria:
Decision Making Companion Tool**

<p>1 _____ YES</p> <p>Will the student be in grade 3, 4, 5, 6, 7, 8, or 11 by September 1 of the school year during which the IEP will be operative?</p> <p>Additional consideration: The grade level listed for the student in the Pennsylvania Information Management System (PIMS) and the PASA digital system must correlate to the assessment decision documented in the current IEP.</p>	<p>2 _____ YES</p> <p>Does the student have significant cognitive disabilities? Pennsylvania defines significant cognitive disabilities as pervasive and global in nature, affecting student learning in all academic content areas, as well as adaptive behaviors and functional skills across life domains.</p> <p>Additional consideration: A significant cognitive disability is not directly defined by a Chapter 14 disability category. Typically students with a primary disability category of Specific Learning Disability or Speech Language Impairment DO NOT meet the definition of a significant cognitive disability. Generally, a student with a significant cognitive disability may be characterized as having intellectual functioning below average – cognitive measures of intelligence 2.5 to 3.0 standard deviations below the mean.</p>	<p>3 _____ YES</p> <p>Does the student require intensive, direct, and repeated instruction in order to learn and generalize academic, functional, and adaptive behavior skills across multiple settings?</p> <p>Additional consideration: The student's course of study includes functional skills. Instruction typically occurs in a one-to-one or small group setting with opportunity to generalize and transfer skills across multiple settings.</p>
--	---	--

4 _____ YES

Does the student require extensive adaptation and support in order to perform and/or participate meaningfully and productively in the everyday life activities of integrated school, home, community, and work environments?

Additional consideration:
A significant cognitive disability is pervasive, affecting student functioning across all academic, social, and community settings. The student is expected to require intensive and ongoing supports after graduation.

5 _____ YES

Does the student require substantial modifications to the general education curriculum?

Additional consideration:
Substantial modifications change the content expectation by a significant reduction in depth, breadth, and complexity of grade-level standards as exemplified in the Alternate Eligible Content.

6 _____ YES

Does the student's participation in the general curriculum differ substantially in form and/or substance from that of most other students? Students found eligible to take the PASA must have measurable annual goals and short-term objectives reflected in the IEP.

Additional consideration:
Students with the most significant cognitive disabilities likely require objectives, materials, prompting hierarchies, and teaching modalities different from the general education curriculum. The student's goals and objectives typically reflect the Alternate Eligible Content.

PASA eligibility determinations are NOT based on:

- IQ score or disability category alone (i.e., All students with an intellectual disability do not automatically qualify for the alternate assessment.)
- English Learner (EL) Status
- Poor attendance
- Expected poor performance on the general assessments
- Educational environment or instructional setting
- Low reading or achievement level
- Anticipated disruptive behavior or emotional duress
- Impact of scores on accountability system
- Administrative decision

State Testing Accommodations

The Individuals with Disabilities Education Act (IDEA) requires the participation of ISPA students with disabilities in state- and district-wide assessments. Specific IDEA requirements include the following:

A test feature is considered an accommodation when the educational team has determined that it is necessary for the student to participate in the assessment. For example, any student may request the read aloud of a word, phrase, or test item on the Mathematics, Algebra, Science, Biology, multiple choice Conventions of Standard English items, and Text Dependent Analysis prompt in Grades 4-8 Reading sections of the ELA test. Since this option is allowable for all students, it is considered a test feature. Although this is considered a text feature, the read aloud of allowable test parts is also considered an accommodation when the educational team has determined it is necessary for the student to access the test materials. Therefore, it must be documented on the student's educational plan.

Link to PSSA Resources	PA System of School Assessment (PSSA)
Link to Keystone Exams Resources	Keystone Exams
Link to PA Alternative System of Assessment (PASA)	Pennsylvania Alternative System of Assessment (PASA)
Link to Parental Rights & Procedural Safeguards	Procedural Safeguards Notice - School Age
Link to Rights of Students with Disabilities	Know Your Rights: Students with Disabilities in Charter Schools

Post-secondary Transition

According to the Pennsylvania Code (22 PA Code § 12.1(a)), "...All persons residing in this Commonwealth between the ages of 6 and 21 years are entitled to a free and full education in the Commonwealth's public schools." Based on the Pennsylvania Public School Code of 1949, as amended (24 P.S. § 13-1301), "...Notwithstanding any other provision of the law to the contrary, a child who attains the age of 21 years during the school term and who has not graduated from high school may continue to attend the public schools in his/her district free of charge until the end of the school term..." The school term, as defined in the Pennsylvania Public School Code of 1949 (24 P.S. § 1-102), is "...the period of time elapsing between the opening of the public schools in the fall of one year and the closing of the public schools in the spring of the following year..." For students with disabilities for which a free appropriate public education (FAPE) includes extended school year services, the school term includes the summer extended school year services

Graduation Options for Students with Disabilities

According to the Pennsylvania Code (22 PA Code § 4.24(g)), a student with disabilities may graduate one of two ways. A student with disabilities may graduate either through the fulfillment of high school graduation requirements set forth in Chapter 4 (relating to academic standards and assessment) or upon the completion of his/her individualized education program (IEP) goals. Graduation with a regular high school diploma is a change in educational placement that requires an IEP team meeting. The IEP team makes the determination whether the student will graduate with a regular high school diploma through meeting the requirements of 22 PA Code Chapter 4. The regular high school diploma that is awarded to students in Pennsylvania is fully aligned with the state's academic content standards and does not include a GED credential, certificate of attendance, or any alternative award.

Participation in Graduation Ceremonies

According to the Pennsylvania Public School Code of 1949, as amended (24 P.S. § 16-1614), a board of school directors of a school district, an area vocational-technical school or a charter school shall allow a student with a disability, whose IEP prescribes continued special education programs beyond the fourth year of high school, to participate in commencement ceremonies with the student's graduating class and receive a certificate of attendance, provided that the student has attended four years of high school regardless of whether the student has completed the IEP. The LEA would not create the diploma until the student graduates with a regular diploma. A diploma is dated and awarded when the student with disabilities actually graduates.

Termination of the Right to a FAPE

The receipt of a regular high school diploma terminates a student's right to a FAPE. Whether a student's right to a FAPE is terminated by the receipt of a regular high school diploma or aging out, the LEA must provide the student with a summary of academic achievement and functional performance, which shall include a recommendation on how to assist the student in meeting their postsecondary goals (34 CFR § 300.305(e)).

When the student graduates with a regular high school diploma, this constitutes a change in educational placement. The LEA must provide the parents with prior written notice for this change in educational placement (34 CFR § 300.102(a)(3)), including an explanation of why the LEA is proposing the change and a description of each evaluation procedure, assessment, record, or report used as a basis of the proposed action. If the student is to graduate with a regular high school diploma prior to the age of 21, the parents have the right to accept or refuse the LEA's recommendation. The recommendation must be appropriate, clearly defining the postsecondary goals, and outline the processes designed to assist the student during the postsecondary transition. If the parents refuse the change in educational placement, they must file for mediation or due process to invoke pendency/stay put.

The recommendation for graduation must be appropriate. A student who has aged out of eligibility under the Individuals with Disabilities Education Act or received a regular high school diploma may be entitled to compensatory education if the LEA inappropriately graduated him or her, or otherwise failed to provide a FAPE during the student's period of eligibility, even if the parent approved the Notice of Recommended Educational Placement/Prior Written Notice. This may include the period of time a student was without a program of education due to an inappropriately issued diploma.

Age of Eligibility & Extended School Year

If a student with a disability turns 21 years of age during the school term, that student may be eligible for extended school year services during the subsequent summer. The IEP team must determine whether that student is eligible for extended school year during the summer. If the IEP team determines that extended school year is a part of a FAPE, that student must be provided with extended school year services during the summer after the end of the school term. If a student graduates at the conclusion of the extended school year program with a regular high school diploma, ISPA will issue a Notice of Recommended Educational Placement/Prior Written Notice, officially proposing the student's exit from special education.

Even though a student with a disability completes the necessary credits and fulfills his/her IEP goals and can graduate with a regular high school diploma, the IEP team may determine that student eligible for Extended School Year services during the subsequent summer. If the IEP team determines that Extended School Year is part of FAPE, that student must be provided with Extended School Year services during the summer after the end of the school term. At the completion of the summer Extended School Year program, the LEA would issue the regular high school diploma and notice of Recommended Education Placement/Prior Written Notice exiting the student from special education. In either case, whether the student ages-out or graduates with a regular diploma and participates in the Extended School Year summer program, the LEA has fulfilled its duty to provide the student with FAPE.

Transfer of Rights

ISPA takes the age of the child and type or severity of disability into consideration with regard to the extent to which children are afforded rights of privacy similar to those afforded to parents. The age of majority in Pennsylvania is 21 years, thus IDEA rights of parents do not transfer to students at age 18. Under the regulations for the Family Educational Rights and Privacy Act of 1974 (34 CFR 99.5(a)), the rights of parents regarding education records are transferred to the student at age 18. The term 'age of majority' is the legal age established under state law at which an individual is no longer a minor and, as a young adult, has the right and responsibility to make certain legal choices that adults make.

All of the educational rights provided to the parents transfer to the student when he or she reaches the age of majority. These educational rights may include the rights to: • receive notice of and attend Individualized Education Program (IEP) meetings • consent to reevaluation • consent to change of placement • request for mediation or a due process hearing to resolve a dispute about evaluation, identification, eligibility, IEP, placement, or other aspects of a free appropriate public education (FAPE)

Educational Benefit Review (EBR)

The purpose of the EBR is to determine whether a student's current IEP is reasonably calculated for the student to receive educational benefit. The EBR process involves comparing the student's current IEP with the prior two (2) IEPs and guides teams through the examination of specific components of the IEP.

Educational benefit can be measured in a variety of ways, including, but not limited to the following:

- Achieving passing grades
- Advancing from grade to grade
- Making progress toward meeting annual goals
- Improving scores on state & district assessments

As the team completes the EBR process for each student, the team must consider the answers to the 10 questions below to determine educational benefit. Questions 1-9 will guide the review team in collecting and analyzing data to make a final determination (question 10) as to whether or not the student has received educational benefit. The Year 3 IEP is used to determine whether the child is receiving educational benefit. The purpose of looking at the two previous years, is to gain background knowledge about how the current IEP was developed. Please review the below information for best practices regarding the process of measuring educational benefit for an individual student.

EBR Review Process



1. **Chart the student's IEP information for a three-year period**, considering each IEP separately and including progress reports, test scores, report card grades, and comments
2. **Analyze relationships within IEP components.** The purpose of looking at components from the two previous years' IEPs is to gain background on how the current IEP was developed. The team determines progress across three years. If an IEP goal is no longer present, the team must examine the data to determine whether the goal was achieved.

3. **Compare progress and look for patterns across three consecutive IEPs.** A review of three consecutive IEPs will help the LEA's designated EBR team determine whether 1) the student was making progress, and 2) that appropriate adjustments and revisions were made to the student's IEP.

As the EBR process is conducted for an individual student, the following 10 questions must be considered to determine educational benefit:

1. Are the assessments complete and do they identify all of the student's needs, including post-secondary outcomes and/or career assessment/functional vocational evaluation for secondary students?
2. In 'Year 3,' does the Present Levels of Academic Achievement

As a means to ensure special education program implementation is provided to students with integrity, ISPA will utilize this EBR approach as a best practice.

Positive Behavior Support & Discipline

Disciplinary Exclusions: Suspensions & Expulsions

All ISPA students subject to disciplinary exclusions are protected by due process procedures in 22 Pa. Code Chapter 12. In addition, ISPA must first determine, when contemplating a disciplinary exclusion of any student, whether the student is eligible for services under 22 Pa. Code Chapter 14 or 711. If the student is eligible for special education, ISPA must then determine whether the disciplinary exclusion being contemplated is a change in educational placement, as described in 22 Pa. Code § 14.143 or § 711.61.

According to 22 Pa. Code §§ 14.143 & 711.61, an intended disciplinary exclusion of a student eligible for special education is a change in educational placement in any of these three situations:

1. The disciplinary exclusion is for more than 10 consecutive school days;
2. The disciplinary exclusion, when cumulated with other disciplinary exclusions in a single school year, exceeds 15 school days; or
3. The disciplinary exclusion (for any length of time) involves a student with an intellectual disability.

Alternatives to Suspension & Expulsion

Alternatives to Consequences

Parent Involvement/Supervision. Parents are invited to help school administrators identify ways they can provide closer supervision of their children while in school or be more involved with their children's schooling. Better communication and frequent contacts between parents, teachers, and administrators, as well as coordinated behavior change approaches, can be very useful and could be formalized into a disciplinary procedure.

Behavior monitoring. A variety of strategies are implemented to closely monitor behavior. These techniques include behavior check sheets for teachers' students, and parents; behavior charts; and student feedback sessions about behavior. These strategies result in positive feedback from teachers and parents when appropriate behavior occurs.

Behavior Contracting/Problem Solving. Develop a negotiated behavior contract with students, which includes specifics about what students will do, what adults will do, and the planned consequences. Contracts include reinforcing consequences for completion of the contract, and consequences for continuing problem behavior. These are created individually for specific students, and consequences are negotiated and agreed to by both parties (student and adult).

Strategies for Preventing Suspension & Expulsion

In addition to alternative consequences, there are a variety of other preventative practices that may help to reduce the potential for serious behavioral infractions that would violate a code of conduct. These supports for behavior may also play a role in preventing inappropriate behavior from occurring before it becomes a discipline issue. Variations of the following sample supports could be considered for certain students as a means to prevent behaviors from becoming an impediment to a child's learning.

Provide opportunities for building adult/student relationships. Encourage staff to engage in conversations with students, to get to know them as individuals, and to share their own stories and beliefs.

Coordinated Behavior Plans. Some students need the creation of a structured, coordinated behavior support plan specific to the student and based on the function of the targeted behavior. The support plan focuses on increasing desirable behavior, replacing inappropriate behaviors, reinforcing the appropriate behavior, and withholding reinforcement of the targeted behavior. Data is used to determine if progress is being made and if further assessment or other intervention strategies need to be included.

Mediation programs. Teach students and staff about nonviolent conflict resolution strategies, and permit students and staff to use and experience these in school related to significant school issues. Peer mediation may be one example but could be expanded to include mediation of teacher-student conflicts.

Provide conflict de-escalation training. Train all staff, especially teachers, in how to de-escalate conflict and avoid power struggles. This will help by keeping minor conflicts from getting to the point of being discipline problems.

Alternative Programming. For some students, especially at the secondary level, it is possible to identify changes in students' schedule, classes, or programs that avoid problem environments or situations, but still permit continued access to curriculum and school. This includes independent study, work experience, alternative location, alternate times, or other creative programming alternatives. Such changes should be specific to individual students' needs and permit credit accrual and progress toward graduation.

Mini Courses. Schools develop short, stand-alone units or modules on topics related to various types of inappropriate behavior. Module activities may include readings, videos, workbook tasks, tests, and oral reports. The modules are designed to teach awareness, knowledge, or skills about targeted areas in order to promote students' behavioral change.

Restitution. Students are assigned to provide work that would repair or restore environments they have damaged. This includes cleaning up graffiti or repairing acts of vandalism. This also includes an option of having students select (or be assigned) other related projects to clean or make attractive in the school environment.

Manifestation Determination

The LEA must first conduct and document a manifestation determination for a disciplinary change in educational placement. An eligible student may be removed to a 45-school-day interim alternative educational setting without the required manifestation determination if the student: 1) Carries a weapon or possesses a weapon at school, on school premises, or at a school function; 2) Knowingly possesses or uses illegal drugs, or sells or solicits the sale of a controlled substance, while at school, on school premises, or at a school function; or 3) Inflicts serious bodily injury upon another person while at school, on school premises, or at a school function. 34 C.F.R. § 300.530(g).

IDEA regulations require the parent and relevant members of the student's Individualized Education Program (IEP) team (as determined by the LEA and parent) to determine whether conduct is a manifestation of a student's disability. Federal regulation requires that a manifestation determination review (MDR) be conducted within 10 school days of any decision to change the educational placement of a student with a disability because of a violation of a code of student conduct.

The regulations at 34 C.F.R. § 300.530(f)(1) require that if the MDR team determines that the conduct **was** a manifestation of the student's disability, the IEP team must either conduct a functional behavioral assessment, unless the ISPA had conducted a functional behavioral assessment before the behavior that resulted in the change of educational placement occurred, and implement a

behavioral intervention plan for the student; or if a behavioral intervention plan already has been developed, the IEP team must review the behavioral intervention plan and modify it, as necessary, to address the behavior.

If the MDR team determines a student's behavior **was not** a manifestation of the student's disability, then the LEA may proceed with the disciplinary exclusion via the procedures for changing educational placement. IDEA 2004 provides that parents may dispute the manifestation determination by requesting a due process hearing, thereby invoking pendency. Such hearings, as well as parent-requested hearings regarding disciplinary exclusions which are changes in educational placement, must be expedited.

If during the manifestation determination review, the team determines that the conduct was the direct result of a failure to implement the IEP, the ISPA must take immediate steps to remedy the deficiencies. For children placed in a 45-school-day interim alternative educational setting under 34 C.F.R. § 300.530(g), there is no requirement for a manifestation determination.

ISPA will follow the Manifestation Determination Review process, for any student who accumulates 10 consecutive unlawful absences and may be considered for additional truancy escalations which include the option of withdrawal from active enrollment. The Manifestation Determination Review will ensure ISPA considers factors surrounding the student's disability and the school's implementation of the IEP. Once the team reviews all factors, a determination can be made regarding any impact the student's disability had in the student's ability to regularly attend school.

RESOURCE LINK: [PDE BEC Disciplinary Exclusions of Students Who Are Eligible for Special Education](#)

Functional Behavior Assessment (FBA)

Functional Behavioral Assessment (FBA) is a process for identifying problem behaviors and developing interventions to improve or eliminate those behaviors.

An FBA consists of information-gathering procedures that result in a hypothesis about the function(s) that the behavior is serving for the student. The process also results in the identification of environmental antecedents (what happened before the behavior occurred) and consequences (what happened after the behavior occurred) that are maintaining the behavior. The information gathered is used to develop an effective and efficient behavior plan.

An FBA is generally understood to be an individualized evaluation of a child in accordance with 34 CFR §300.301 through §300.311 to assist in determining whether the child is, or continues to be, a child with a disability. The FBA process is frequently used to determine the nature and extent of the special education and related services that the child needs, including the need for a positive behavior support plan. ***As with other individualized evaluation procedures, and consistent with 34 CFR §300.300 (a) and (c), parental consent is required for an FBA to be conducted as part of the initial evaluation or a reevaluation.***

Information gathered through the FBA process is done through reviewing records, input from those regularly observing the student's behavior, direct observation across settings, and considerations of contributing events and/or environmental factors. As a result, an FBA will allow for the school-based team to proceed with the:

1. Development of a specific, clear description of the behavior of concern
2. Identification of environmental factors such as antecedents and consequences corresponding with the behavior
3. Development of summary statements identifying the perceived function(s) of the behavior of concern

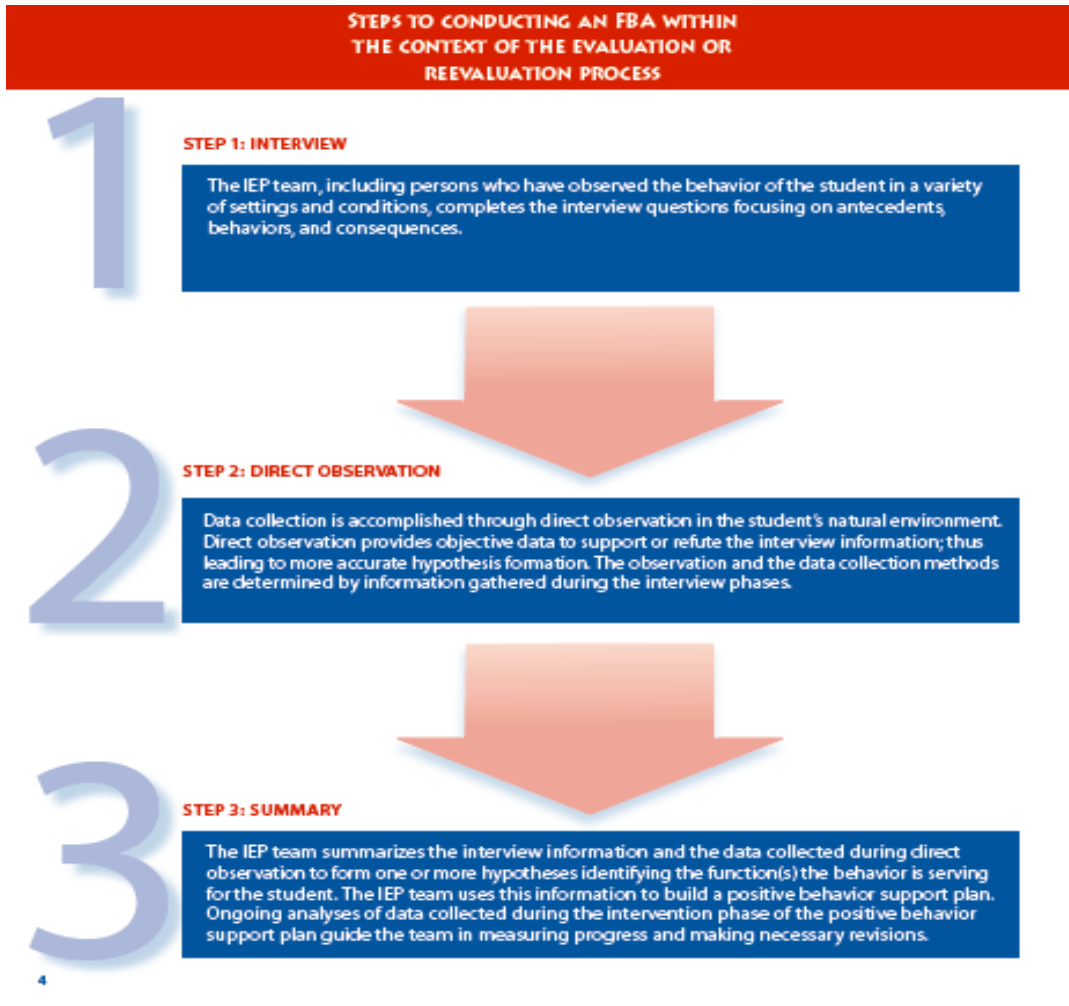
An FBA must be conducted:

- Whenever the Individualized Education Program (IEP) team (1) determines that a student's behavior is interfering with his/her learning or the learning of others, and (2) requires additional information to provide appropriate educational programming.

- When a behavior violates a “code of student conduct” that results in a change of placement and is determined by the IEP team to be a manifestation of the student’s disability.
- When the school refers the student to law enforcement.
- When a student is removed from his/her current placement as a result of weapon possession, and/or illegal drug possession/use, and/or serious bodily injury.

Conducting an FBA along with an Initial Evaluation or Reevaluation

The process of investigating the cause (or ‘function’) of a student’s behavior involves an in-depth analysis of all of the factors involved in the environment in which a behavioral concern is observed.



Use & Reporting of Restraints

PA Definition of Restraint

Chapter 14 defines the term ‘restraint’ as:

- A. The application of physical force, with or without the use of any device, for the purpose of restraining the free movement of a student’s or eligible young child’s body.
- B. The term does not include briefly holding, without force, a student or eligible young child to calm or comfort him, guiding a student or eligible young child to an appropriate activity, or holding a student’s or eligible young child’s hand to safely escort him/her from one area to another.

- C. The term does not include hand-over-hand assistance with feeding or task completion and techniques prescribed by a qualified medical professional for reasons of safety or for therapeutic or medical treatment, as agreed to by the student’s or eligible young child’s parents and specified in the IEP. Devices used for physical or occupational therapy, seatbelts in wheelchairs or on toilets used for balance and safety, safety harnesses in buses, and functional positioning devices are examples of mechanical restraints excluded from the definition of a restraint.
- D. Restraints to control acute or episodic aggressive or self-injurious behavior may be used only when the student is acting in a manner as to be a clear and present danger to himself / herself, to other students, or to employees, and only when less restrictive measures and techniques have proven to be or are less effective

ISPA, along with all Pennsylvania school entities, must maintain and report data on the use of restraints as prescribed by the Secretary. The report shall be reviewed during cyclical compliance monitoring conducted by the Bureau of Special Education Department (§14.133(c)(5) and 711.46(c)(5)).

The new provisions in 22 Pa. Code Chapter 14.133 and Chapter 711.46 require that behavior support programs and plans be based on a functional assessment of behavior (see prior section on Functional Behavior Assessments). Restraints are only to be considered as a measure of last resort, only after other less restrictive measures have been used.

The use of prone restraints is prohibited in PA educational settings. Prone restraints are those in which a student or eligible young child is held face down on the floor.

New provisions in Chapter 14 and Chapter 711 were added regarding positive behavior support plans. This section adds a definition of restraints and provides that when restraints are used, the education entity shall notify the parent and conduct an Individualized Education Program (IEP) team meeting within 10-school days unless the parent waives the need for a meeting in writing.

For more information regarding this regulation, please see the PDE resource at [this link](#).

IEP Progress Reports

Progress Reporting Schedule (IEP) – Special Education Teachers, (also referred to as Case Managers), are tasked with maintaining oversight of the implementation of the IEPs for their student caseload, as well as the tracking of progress on IEP goals. As a general practice, ISPA strives to achieve progress monitoring probes with students on a bi-weekly, with greater or lesser frequency as determined necessary for individual students. Quarterly reports of progress are also issued to families, to provide an update status on a student’s progress toward mastering each respective annual goal. Please be advised that multiple factors can contribute to the validity of progress ISPA may have available for report.

Inconsistent student attendance is one of the most common factors leading to growing gaps in student achievement and decreased student engagement in the learning process. Availability for instruction promotes more opportunities for learning as well as for the essential components of necessary supports and services. ISPA will refer to patterns in attendance and participation in scheduled instructional support sessions to inform all stakeholders of additional considerations of student data.

The following graphic provide a breakdown of the anticipated dates for ISPA to update IEP reports of progress for parents/guardians. These dates coincide with the school-wide dates for issuing quarterly report cards/course grades.

Quarter	Quarter End Date	Progress Report Send Date
1	11/7/2019	11/14/2019
2	1/24/2020	1/31/2020
3	4/3/2020	4/7/2020
4	6/12/2020	6/17/2020

**Quarterly Progress Reports differ from Quarterly Report Cards in that progress reports are specific to the individual IEP goals a student has*

Resource Link: Reporting IEP Progress

[PaTTAN Publication: Formative Assessment & IEP Progress Monitoring](#)

Extended School Year Services (ESY)

For all students with disabilities, Extended School Year eligibility must be considered at each IEP team meeting. This determination must be made even if the child's parents/LGs have not specifically requested that their child be evaluated for Extended School Year programming. This consideration also applies to students with disabilities who are placed by ISPA in an approved private school or other alternate educational facilities. Approved private schools and other facilities must share necessary information with ISPA, when applicable, so that a timely decision can be made by the IEP team. However, the ultimate responsibility for timely IEP review and revision rests with ISPA.

Parents must be notified of the annual IEP team review meeting in order to ensure their participation in ESY determination is accessible and encouraged. For purposes of an Extended School Year eligibility determination, IEP must make the determination of the need in a timely manner so that children can receive the necessary services in compliance with a free appropriate, public education (FAPE).

The timing of an Extended School Year determination is dependent on whether the student is a member of the Armstrong group, as defined by the Armstrong Remedial Order No. 2 Guidelines. **The IEP team review meeting for ESY determination must occur no later than February 28 of each school year for the Armstrong group** (as listed below). This date may require ISPA to reschedule the annual IEP team review, or to conduct a separate Extended School Year IEP team meeting for this review (see 22 Pa. Code 13.132(d) and 22 Pa. Code 711.44(d)).

Students in the Armstrong group are those students with a severe disability, such as:

1. Autism
2. Emotional disturbance
3. Intellectual disability
4. Severe multiple disabilities and/or other neurological or cognitive impairments

ISPA Review Procedure

The importance of making an Extended School Year determination based on data and other reliable sources is well established. It should be noted that quantitative data is only one of the types of information that can be used to make Extended School Year decisions. Predictive data, such as reports by parents, medical or other agency reports, observations and opinions by educators and others, can also provide a basis for an eligibility determination. Some examples of information that can be helpful in making an eligibility determination may include:

- Progress on goals in consecutive IEPs
- Progress reports maintained by educators, therapists and others, such as guidance counselors or staff supervising extracurricular activities, having direct contact with the student before and after interruptions in the education program
- Reports by parents of negative changes in adaptive behaviors or in other skill areas
- Medical or other agency reports indicating degenerative-type difficulties, which become exacerbated during breaks in educational services
- Observations and opinions by educators, parents and others such as guidance counselors or staff supervising extracurricular activities
- Results of tests including criterion-referenced tests, curriculum-based assessments, ecological life skills assessments and other equivalent measures.

ESY Eligibility Criteria:

Extended School Year determinations can be based on the traditional regression/recoupment criteria as well as other factors, such as:

- The extent to which the student has mastered and consolidated an important skill or behavior at the point when educational programming would be interrupted
- The extent to which the student reverts to a lower level of functioning as evidenced by a measurable decrease in skill or behaviors which occur as a result of an interruption in education programming (regression)
- The extent to which the student has the capacity to recover the skills or behavior patterns in which regression occurred to a level demonstrated prior to the interruption of educational programming (recoupment)
- The extent to which the student's difficulties with regression and recoupment make it unlikely that the student will maintain the skills and behaviors relevant to IEP goals and objectives.
- The extent to which a skill or behavior is particularly crucial for the student to meet the IEP goals of self-sufficiency and independence from caretakers
- The extent to which successive interruptions in educational programming result in a student's withdrawal from the learning process

If these factors make it unlikely that the student will maintain skills and behaviors relevant to IEP goals and objectives, or if the student otherwise requires Extended School Year services to receive FAPE, the student is eligible for Extended School Year.

For a child to be found eligible for Extended School Year, it is not necessary that the child have first experienced regression during an interruption in educational programming in order to receive Extended School Year during the subsequent program break.

ESY Determination & The Armstrong Group:

The Notice of Recommended Education Placement/Prior Written Notice, containing the IEP team's determination regarding Extended School Year eligibility, must be issued to the parents in a timely manner. [For students in the Armstrong group, this NOREP must be sent to parents no later than March 31 of the school year the Extended School Year determination was made.](#) If the child has been determined eligible for Extended School Year, the program specifics must be included in the IEP.

Notification for ESY Determinations:

The timelines established for ESY determination for students within the Armstrong group, do not apply to other students with disabilities. However, Extended School Year determinations must still be made in a timely manner in accordance with the requirements in the Pennsylvania Code (22 Pa. Code Chapter 14, and 22 Pa. Code Chapter 71 I). If the parents of those non-Armstrong students with disabilities disagree with the ISPA's recommendation, the parents will be afforded their rights to procedural safeguards for due process.

ISPA's notice to the parents concerning Extended School Year eligibility or ineligibility must be sent by Notice of Recommended Education Placement/Prior Written Notice (NOREP/PWN). The Notice of Recommended Education Placement/Prior Written Notice for ESY only needs to be issued if the IEP team is:

- Proposing to add Extended School Year services to an IEP that previously did not have it
- Proposing to delete the provision of Extended School Year services from an IEP
- Refusing to initiate the provision of Extended School Year services requested by the parent
- Proposing or refusing to change the provision of the Extended School Year program

When Extended School Year services are offered by ISPA, the IEP that accompanies the Notice of Recommended Education Placement/Prior Written Notice must contain a:

- Description of the type and amount of Extended School Year service

- Projected beginning dates and anticipated duration of service
- Frequency
- Location

As with all IEP team decisions, the Extended School Year components of the IEP must be individualized to meet the specific child's needs and must be developed with the participation of the parents at an IEP team meeting.

For additional information regarding the eligibility criteria for ESY, please review the resource at this [link](#).

Exit from or Parent Revocation of Special Education Services

ISPA must reevaluate a child with a disability before determining that the child is no longer a child with a disability who requires special education services. However, reevaluation is not needed when the student

- graduates with a regular diploma, or
- exceeds the age of eligibility for FAPE (age 21) before the start of the school year.

ISPA must, however, provide the student with a summary of academic and functional performance that includes recommendations for meeting postsecondary goals when the student is graduating with a regular diploma or aging out of school. Best practice would also include providing the summary of performance for the student who receives a special education diploma or other exit document.

Parents who request that their child be taken out of special education may be asked to provide the request in writing. Once completed, parents will be provided a summary of their student's current academic and functional performance at the point of revocation.

- Process for Dismissal
- (SOP)Summary of Performance Guidance

IEP Meeting Participants

-

Related Services

ISPA provides related services to all eligible students according to what is prescribed by the Individual Education Plan. Contracts are secured with private clinics, therapists, hospitals and local districts throughout the state to provide therapy for FULL INSIGHT PA students. ISPA is responsible for providing related services and will attempt to secure services within a reasonable distance from the student's residence.

Once a student has been identified as needing related services as outlined on their IEP, it is the responsibility of the assigned teacher to the school's Related Service Manager, so that a service provider can be assigned to the student.

If the related service is occupational or physical therapy or evaluation, it is the parent's responsibility to provide a prescription from their child's physician for that service. This can be sent to the ISPA office or assigned special education teacher.

Once a therapist is identified, the therapist contacts the family to set up the therapy schedule. Once the therapist is provided to family, the school has met the obligation of the IEP in providing access to services.

It is the contracted provider's responsibility to provide all required documentation of services within given timelines and to notify the FULL INSIGHT PA of any absences from therapy and/or any concerns that they may have concerning the student's academic needs or performance.

It is the parent's responsibility to ensure their student attends therapy sessions and to notify the FULL INSIGHT PA of any concerns with the contract provider or any changes that may prohibit the student from attending therapy.

If a student has consistent truancy then the IEP team will meet to determine if services are still deemed necessary. The parent has the right to decline services for their student at any time.

A statement of assurance is provided to the parent regarding provision of services for any related services that are deemed necessary and appropriate by the IEP team but do not have a therapist available or assigned.

Compensatory Services

When a student has not been provided therapy services that are deemed appropriate on the student's IEP due to the school's failure to locate a therapist, that student is owed compensatory services. These services can be delivered within a normal school week in conjunction with current services or during school breaks when normal services would not be provided. The determination as to the appropriate method of delivering compensatory services should be done in consultation with the therapist as some students will not benefit from additional services within small time frames.

A plan for the delivery of compensatory services will be developed by the IEP team within 2 weeks of a therapy provider being identified. Compensatory services will not be provided when the parent has declined a provider who is within a reasonable distance (60 minute drive or less) from the student's home address. Compensatory services are calculated using the start date of the services on the IEP and the first day that therapy has been provided.

Compensatory services will not be provided for sessions that are missed due to student or parent illness, transportation issues, or general truancy. The compensatory plan will be based upon the statement of assurance provided to the parent at previous IEP meeting. The IEP team will meet to determine appropriate therapy frequency and duration and then state within the IEP the time frame that services will be delivered and how they will be delivered.

Assistive Technology

Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device (34 CFR 300.6). AT services may include Assessment of AT needs:

- Providing for acquisition of AT through purchase, rental, or other means.
- Selecting, customizing, or adapting AT devices.
- Other services are those that are necessary to enable the student and/or IEP team to use any AT devices specified in the IEP.

For every student with an IEP, federal and state regulations require that the team consider the student's need for assistive technology devices and services.

What does it mean to consider AT? Consideration of AT, in the context of IEP development, review, or revision, is intended to be a collaborative process in which team members (including the student and family members) determine whether AT devices or services are needed for the student to access the general education curriculum or meet IEP goals. Helpful questions to guide teams in considering AT can be found in the Annotated IEP ([link to form](#).)

On a case-by-case basis, the use of school-purchased AT devices in a student's home or in other settings is required if the child's IEP team determines that the child needs access to those devices in order to receive FAPE (34 CFR 300.105). This may include providing AT devices or software when needed for homework, or for functional skills that are necessary across environments, such as communication using an augmentative/alternative communication (AAC) device.

The use of AT should allow the student to meet IEP goals, engage successfully in curricular tasks, and participate in academic and social life. Use of AT is not just an educational outcome, but rather a means to achieve in these areas. For some students, it may be appropriate to develop a goal for learning to use certain technology. In most cases, AT is appropriately embedded in a goal (e.g. Using x, student will...).

For additional guidance offered by the PA Department of Education, please consult with the following [link](#).

Accessible Instructional Materials

Federal and state special education statutes require that students with print disabilities be provided with textbook and other materials in accessible formats. Such materials are referred to as Accessible Instructional Materials (AIM) and include digital (electronic) text, braille, audio, and enlarged print. The following information is excerpted from Pennsylvania's Guidelines for the Provision of Accessible Instructional Material, which was issued by the Pennsylvania Bureau of Special Education in January 2010 and is available at www.pattan.net. The guidelines provide local education agencies with direction for identifying, locating, and providing AIM.

PDE Resource for AIM

AIM Acquisition Sources

Once the student's IEP team determines the format that the student needs and can use, AIM may be acquired from a variety of sources. Note that sources may have eligibility criteria and require documentation for enrollment.

- Textbook Publishers (for materials in appropriate formats available for purchase)
- National, federally-funded repositories and programs:
- BookShare www.bookshare.org (for digital text files)
- Learning Ally (formerly Recordings for Blind & Dyslexic) www.learningally.org (for digitally recorded audiobooks)
- American Printing House for the Blind (APH) www.louis.aph.org (for Braille, enlarged print, audio, and digital files)

- Pennsylvania Training and Technical Assistance Network (PaTTAN) AIM Center www.pattan.net (for Braille and enlarged print and to request NIMAS files for conversion to other digital file types for eligible students with print disabilities).

The PaTTAN AIM Center is also a source for technical assistance in locating, converting, and using AIM for LEAs in Pennsylvania.

Resources for Learning More About AIM

National Center on Accessible Instructional Materials <http://aim.cast.org/>

This site serves as a resource to educators, parents, and others interested in learning more about and implementing AIM. Resources at this site include:

- The AIM Navigator: an online application that facilitates the process of decision-making about accessible instructional materials for an individual student by IEP or other decision-making teams
- AIM Explorer: a free, downloadable simulation tool that enables teams to explore various settings of features found in text readers and supported reading software

Special Education Grievances & Dispute Resolution

Insight PA believes that a collaborative approach to resolving any student-centered concern can be the most efficient and most effective method for maintaining and/or improving positive student outcomes. If a family does not believe a resolution has or can be achieved through discussing their specific concerns with the student's Insight PA team, PDE does offer the following options as it relates to escalating their concerns:

Alternate Options Prior to Due Process

The Office for Dispute Resolution (ODR) of Pennsylvania is committed to seek out and offer varying alternative dispute resolution activities and options for constituents. ODR understands the importance of due process; however there are several steps that can be taken prior to filing for a due process hearing in an attempt to reach a resolution. The alternative dispute resolution options that ODR offers have shown to be successful in helping parties reach an agreement.

PDE has a [Special Education Consult Line](#) resource for families who would like to receive State feedback regarding a special education-related issue or concern.

1. **IEP Facilitation:** A voluntary process that can be used when all parties to an IEP meeting agree that the presence of a neutral third party would help facilitate communication and the successful drafting of the student's IEP.
2. **Hearing Officer Settlement Conference:** A voluntary service for those parties who are close to a resolution, but have identified sticking points or roadblocks, that work with a Settlement Hearing Officer to see if those sticking points/roadblocks can be overcome in order to move to finalizing a resolution and avoiding a hearing.
3. **Resolution Meeting Facilitation:** A voluntary process during a Resolution Meeting where a trained facilitator works with both parties to resolve disagreements, which could eliminate the need to move forward with due process.

Video links: [Mediation](#); [IEP Facilitation](#); [Resolution Meetings](#)

Formal Due Process Hearings

Due process hearings are similar to trials, with the Hearing Officer presiding and acting as a judge. An attorney will represent the educational agency. The parent may also be represented by an attorney, or may proceed without counsel. Witnesses are questioned and cross-examined, and evidence is admitted into the record for the Hearing Officer's consideration. At the conclusion of the hearing, the Hearing Officer issues a written decision, which is a legally enforceable document setting forth the legal obligations of all the parties.

Disputes Regarding Manifestation Determinations

When a due process hearing is requested to challenge a manifestation determination or a disciplinary exclusion, it must be expedited. Section 300.532(c)(2) requires that a hearing occur within 20 school days of the date the due process complaint requesting the hearing is filed. The Office for Dispute Resolution will assign a hearing officer to review disputes requiring an expedited hearing. A hearing officer, in an expedited due process hearing, may order a change in the placement of a student with a disability to an appropriate interim alternative educational setting for not more than 45 school days if the hearing officer: 1) Determines that maintaining the current placement of the student is substantially likely to result in injury to the student or to others; 2) Considers the appropriateness of the student's current placement; 3) Considers whether the LEA has made reasonable efforts to minimize the risk of harm in the student's current placement, including the use of supplementary aids and services; and 4) Determines that the interim alternative educational setting that is determined by the IEP team so as to enable the student to continue to progress in the general curriculum, although in another setting, and to continue to receive those services and modifications, including those described in the student's current IEP, that will enable the student to meet the goals set out in that IEP, and includes services and modifications that are designed to prevent the behavior from recurring (34 CFR 300.530(d)(1)(ii) and (ii)).

After meeting all procedural requirements, if the IEP team recommends a disciplinary exclusion which would constitute a change in educational placement, LEAs must follow the notice requirements for changes in educational placement. If the parents dispute the

LEA's proposed change in educational placement and request a due process hearing, then the pendency requirements under 34 C.F.R. § 300.533 apply. As mentioned above and further discussed below, however, there are exceptions to pendency.

Pendency

As of June, 2008, state regulations were modified to incorporate pendent placement (stay-put status) for a child during mediation proceedings. These regulations include 22 Pa. Code Chapters 14.162 (s) and 71.162 (e) (State Special Education Regulations).

Mediation remains a voluntary option for parents and local education agencies (LEAs). However, if a parent requests mediation through the Office for Dispute Resolution within ten calendar days of receipt of a NOREP recommending a change in the student's placement, the law now requires that the student remain in the current educational program, unless the parent and LEA agree otherwise. (Disciplinary changes in placement as outlined in 34 CFR 300.530 (c) and (g) are not covered by pendency during mediation.)

Exceptions to Pendency

The following exceptions are applicable in Pennsylvania:

Exception 1: *Immediate or severe discipline problems with students with intellectual disabilities.*

If a discipline problem involving a student eligible for special education with an intellectual disability is immediate or so severe as to warrant immediate action, the LEA must first contact the parents to see if they will agree to the change in educational placement. If the parents agree, the LEA issues notice to the parents. If there is no agreement, the LEA may contact the Pennsylvania Department of Education's (PDE) Bureau of Special Education at 717-783-6134 to request permission to impose a disciplinary exclusion which would be a change in educational placement. When the PDE approves the change in educational placement, the LEA must issue notice to the parents. The PDE cannot approve requests for a change in placement which would continue beyond 10 consecutive days.

Exception 2: *Students eligible for special education who carry a weapon to school.*

IDEA 2004 and 34 C.F.R. § 300.530(g)(1) permit LEAs to change the placement of a student eligible for special education for not more than 45-school-days if he/she brings a weapon to school or at a school function to an interim alternative educational setting. Weapon has the meaning given the term "dangerous weapon" and is defined as a weapon, device, instrument, material, or substance, animate or inanimate that is used for, or is readily capable of, causing death or serious bodily injury, except that such term does not include a pocket knife with a blade of less than 2 ½ inches in length. 18 U.S.C.A. §930(g)(2).

Exception 3: *Students eligible for special education who knowingly possess or use illegal drugs, or sell or solicit the sale of a controlled substance while at school or a school function under the jurisdiction of an LEA.*

The same requirements described in Exception 2 above apply to eligible students who knowingly possess or use illegal drugs or sell or solicit the sale of a controlled substance, while at school, on school premises, or at a school function. 34 C.F.R. § 300.530(g)(2). Illegal drug means a controlled substance (i.e., a drug or other substance identified under schedules I, II, III, IV, or V of the Controlled Substances Act (21 U.S.C. § 812(c)), but does not include a substance that is legally possessed or used under the supervision of a licensed health-care professional, used under any other authority under the Controlled Substances Act, or used under any other provision of federal law.

Exception 4: *Students eligible for special education who inflict serious bodily injury upon another person while at school, on school premises, or at a school function under the jurisdiction of an LEA.*

"Serious bodily injury" means bodily injury which involves: a substantial risk of death; extreme physical pain; protracted and obvious disfigurement; or protracted loss or impairment of the function of a bodily member, organ, or mental faculty. 18 U.S.C. §1365(h)(3).

Exception 5: *Determination by a hearing officer that maintaining the current placement is substantially likely to result in injury to the student or others.*

Under 22 Pa. Code §§ 14.162 and 711.62, impartial hearing officers resolve disputes over the identification, evaluation, educational placement, or provision of a free appropriate public education (FAPE) to an eligible student. IDEA 2004 allows hearing officers to order a change in educational placement to an interim alternative educational setting for not more than 45-school days if the LEA demonstrates that maintaining the current educational placement of the student is substantially likely to result in injury to the student or to others.

Special Education Disputes: Resource Links

Office of Dispute Resolution Resource for Families
Dispute Resolution Procedural Manual
Procedural Safeguards for Families

[Understanding Due Process Hearings](#)
[PA Dispute Resolution Manual](#)
[Procedural Safeguards Notice](#)



July 22, 2019

Mrs. Eileen Cannistraci
Chief Executive Officer
Insight PA Cyber
350 Eagleview Boulevard
Suite 350
Exton, Pa 19341

Dear Mrs. Cannistraci:

Enclosed is the Report of Findings presenting results of the cyclical monitoring which was conducted by the Bureau of Special Education (BSE) in the Insight PA Cyber the week of April 8, 2019.

The Executive Summary is arranged in two parts and includes an Appendix. PART I presents the Summary of Findings including an explanation of the review process and general findings. PART II describes the corrective action process. A description identifying findings of noncompliance, corrective action required, improvement planning needed, and results of interviews of staff and parents can be found in the Appendix. The charter school must complete corrective action within the calendar days as outlined in the Charter School Corrective Action Verification/Compliance and Improvement Plan developed with the BSE Adviser. Follow-up onsite reviews verifying the charter school's completion of corrective action will be conducted by the BSE. The BSE Adviser will contact the charter school to schedule the initial visit within 60 days of issuance of the monitoring report.

34 CFR 300.600 mandates the BSE to carry out monitoring activities and implementation of any necessary corrective action. Legal compliance is the basis on which high quality programs are built. It is policy of the Department of Education to promote and ensure compliance with special education statutes and regulations through an array of activities such as a coordinated program of plan review, compliance monitoring, technical assistance, and funding decisions. However, if the Department does not succeed in obtaining prompt compliance through activities such as monitoring, then more rigorous steps can be taken to make sure compliance is resolved. These include:

- Disapproval or rescinded approval of the local special education plan
- Deferral of the disbursement of state or federal funds pending resolution of the issue
- Reduction of the amount of funds (for example, by the amount of money it takes to provide an appropriate education to a particular child or children) if a charter school is unwilling to provide appropriate services

None of these steps are desirable and none should be necessary if each charter school is familiar with and attentive to the rules governing special education.

If you have any questions about this report, contact Dr. Beth Marvin, the Chairperson of the compliance monitoring team.

Please convey my thanks to all staff who participated in the review. Their time and assistance is appreciated.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Hozella".

Patricia Hozella
Interim Director

Attachments: Executive Summary
Appendix: Detailed Report of Findings, Including Corrective Actions Required

CC: Chairperson
Jill Deitrich
CS Monitoring File



Executive Summary BSE Compliance Monitoring Review of the Insight PA Cyber

PART I SUMMARY OF FINDINGS

A. Review Process

Prior to the Bureau's monitoring the week of April 8, 2019, the Insight PA Cyber was formally notified of the dates the onsite review would be conducted. Notice and invitation to comment was also provided to the Local Task Force on Right-to-Education. The charter school was informed of its responsibility to compile various reports, written policies, and procedures to document compliance with requirements.

While onsite, the monitoring team employed a variety of techniques to gain an in depth understanding of the charter school's program operations. This included:

- Interviews of charter school administrative and instructional personnel
- Review of policies, notices, plans, outcome and performance data, special education forms and formats, and data reports used and compiled by the charter school (Facilitated Self-Assessment)
- Comprehensive case studies (including classroom observations, student file reviews, and interviews of parents and general and special education teachers).

B. General Findings

In reaching compliance determinations, the Bureau of Special Education (BSE) monitoring teams apply criteria contained in federal and state special education regulations. Specifically, these are:

- Individuals with Disabilities Education Improvement Act of 2004
- 22 Pa. Code Chapter 711
- 34 CFR Part 300

This report focuses on compliance with regulatory requirements and also contains descriptive information (such as interview and survey results) intended to provide feedback to assist in program planning.

C. Overall Findings

1. FACILITATED SELF ASSESSMENT (FSA)

The team reviewed the FSA submitted by the charter school and conducted onsite verification activities of the information submitted in the FSA. The onsite verification activities included review of policies, notices, procedures, and file reviews.

FSA	In Compliance	Out of Compliance
Assistive Technology and Services; Hearing Aids	0	2
Positive Behavior Support Policy	0	1
Child Find (Annual Public Notice and General Dissemination Materials)	0	1
Confidentiality	0	1
Dispute Resolution (Due process hearing decision implementation)	0	0
Exclusions: Suspensions and Expulsions (Procedural Requirements)	0	0
Independent Education Evaluation	0	1
Least Restrictive Environment (LRE)	1	0
Provision of Extended School Year Services	1	0
Provision of Related Service Including Psychological Counseling	1	0
Parent Training	0	1
Public School Enrollment	0	0
Surrogate Parents (Students Requiring)	0	1
Personnel Training	1	0
Intensive Interagency Approach	0	0
Summary of Academic Achievement and Functional Performance/Procedural Safeguard Requirements for Graduation	0	0
SPP/APR Indicator 13 (Transition)	0	1
Disproportionate Representation that is the Result of Inappropriate Identification	1	0

IMPROVEMENT PLAN REQUIRED*	Yes	No
Effective Use of Dispute Resolution	0	0
Graduation Rates (SPP)	0	0
Dropout Rates (SPP)	0	0
Suspensions (Rates)	0	0
Least Restrictive Environment (LRE) (SPP)	0	1
Participation in PSSA and PASA (SPP)	0	0
Participation in Charter-Wide Assessment	0	0
Public School Enrollment	0	1
Disproportionate Representation that is the Result of Inappropriate Identification	0	1

*This determination is based on the data used for the monitoring. More recent data provided by the LEA may demonstrate that the LEA does not require an improvement plan for this topic. Please refer to the Corrective Action Verification/Compliance and Improvement Plan for final guidance.

2. FILE REVIEW (Student case studies)

The education records of randomly selected students participating in special education programs were studied to determine whether the charter school complied with essential requirements.

The status of compliance of the Insight PA Cyber is as follows:

Sections of the FILE REVIEW	In Compliance	Out of Compliance	NA
Essential Student Documents Are Present and Were Prepared Within Timelines	68	18	74
Evaluation/Reevaluation: Process and Content	261	10	509
Individualized Education Program: Process and Content	396	83	321
Procedural Safeguards: Process and Content	110	5	5
TOTALS	835	116	909

3. TEACHER AND PARENT INTERVIEWS

Interviews were conducted with parents and teachers of students selected by the BSE for the sample group. The goal is to determine if the charter school involves parents and professionals in required processes (e.g., evaluation, IEP development), whether programs and services are being provided, and whether the charter school provides training to enhance knowledge. Parent and teacher satisfaction with the special education program is also generally assessed.

	# Yes Responses	# No Responses	# of Other Responses
Program Implementation: General Ed Teacher Interviews	150	20	65
Program Implementation: Special Ed Teacher Interviews	182	6	133
Program Implementation: Parent Interviews	114	17	96
TOTALS	446	43	294

4. CLASSROOM OBSERVATIONS

Observations are conducted in classrooms of students selected by the BSE for the sample group.

	# Yes Responses	# No Responses	# of Other Responses
Classroom Observations	0	0	0

5. EDUCATIONAL BENEFIT REVIEW

	In Compliance	Out of Compliance
Educational Benefit Review		X

**PART II
CORRECTIVE ACTION PROCESS**

PART I of this report presented an overall summary of findings. In the Appendix to the report, we have provided the detailed findings for each of the criteria of the compliance monitoring document, i.e. FSA, File Reviews, Interviews and Classroom Observations. The detailed report of findings includes:

- Criteria Number
- Statements of all requirements
- Whether each requirement was met, not met, not applicable or other
- Statements of corrective action required for those criteria not met. *Criteria not met that require corrective action by the charter school are gray-shaded.*

Charter schools are advised that in accordance with requirements of the Individuals with Disabilities Education Act, all noncompliance must be corrected as soon as possible but in no case later than one year from the date of the monitoring report. The BSE is required to verify timely correction of noncompliance, and must report annually to the federal government and the public on this requirement.

Upon receipt of this report, the charter school should review the corrective action and improvement planning required. The report is formatted so that findings from all components of the monitoring are consolidated by topical area. The report lists the finding, and whether corrective action is required. For certain types of findings, corrective action will be prescribed, and will not vary from charter school to charter school. For example, if the finding is that the charter school lacks a specific required policy, it is reasonable to have the BSE prescribe a standardized remedy and timeline for correcting this deficiency. However, the majority of corrective action activities will be individually designed by the charter school based on their own unique circumstances and goals. Consistent with IDEA's general supervision requirements for states, BSE must approve all proposed corrective action.

With respect to the File Review, because students were selected at random, findings are generalized to the entire population of students with disabilities. During the corrective action review, the BSE Advisor will select students at random and will review updated data, i.e. records that were developed subsequent to the monitoring. Consequently, the charter school should approach corrective action on a systemic basis. As indicated above, the charter school is also required to correct student specific noncompliance identified during monitoring under the ICAP process. If there has been a finding of noncompliance in the Educational Benefit Review component, the individual students are identified to the charter school and, because of the significance of the provision of a free appropriate public education (FAPE) to these students; the charter school must take immediate corrective action.

The BSE Adviser will schedule an onsite visit with the charter school within 60 days following issuance of the monitoring report. The BSE Adviser, charter school, and PaTTAN staff will develop a Charter School Corrective Action Verification/Compliance and Improvement Plan. PaTTAN and IU staff are available to assist the charter school.

Upon conclusion of the corrective action process, the charter school will be notified of its successful completion of the monitoring process.

Charter School Corrective Action Verification/Compliance and Improvement Plan - Bureau of Special Education

This form is designed to serve both as a planning tool and as verification of completion of corrective action.

Charter School: Insight PA Cyber

Chief Executive Officer: Mrs. Eileen Cannistraci

Special Education Director/Coordinator: _____

BSE Special Education Adviser: Dr. Beth Marvin

Date of Report: July 22, 2019

Date Final Report Sent to LEA: July 22, 2019

Reminder: The timelines for corrective action of all non-compliance items may not exceed ONE YEAR from the Date Final Report Sent to LEA

First Visit Date: _____

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
						Topical Area 1: Policies, Practices, and Procedures			
	N					1. FSA-ASSISTIVE TECHNOLOGY AND SERVICES Standard: The Local Education Agency (LEA) observed the requirement that the provision of assistive technology is reflected in the student's IEP			
	N					1A. FSA-HEARING AIDS Standard: Each public agency shall ensure that the hearing aids worn in school by children with hearing impairments, including deafness, are functioning properly. Each public agency must ensure that the external components of surgically implanted medical devices are functioning properly			
	N					2. FSA-POSITIVE BEHAVIOR SUPPORT Standard: LEA complies with the positive behavior support policy requirements.			
	N					3. FSA-CHILD FIND Standard: LEA demonstrates compliance with annual public notice requirements.			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
	N					4. FSA-CONFIDENTIALITY Standard The LEA is in compliance with confidentiality requirements.			
		X				5. FSA-DISPUTE RESOLUTION (DUE PROCESS HEARING DECISION IMPLEMENTATION) Standard: The LEA uses dispute resolution processes for program improvement.			
		X				8. FSA-PROCEDURAL REQUIREMENTS FOR SUSPENSION Standard: The LEA adheres to procedural requirements in suspending students with disabilities.			
	N					10. FSA-INDEPENDENT EDUCATIONAL EVALUATION Standard: The LEA documents a procedure for responding to requests made by parents for an independent educational evaluation at public expense.			
Y						11A. FSA-LEAST RESTRICTIVE ENVIRONMENT Standard: The LEA's continuum of special education services supports the availability of LRE under 34 CFR Part 300.			
Y						12. FSA-EXTENDED SCHOOL YEAR SERVICES			
Y						13. FSA-RELATED SERVICE INCLUDING PSYCHOLOGICAL COUNSELING			
	N					15. FSA-PARENT TRAINING Standard: Parent opportunities for training and information sharing address the special knowledge, skills and abilities needed to serve the unique needs of children with disabilities.			
						INTERVIEW RESULTS (Parent)			
						P 62. My school district/charter school makes available training related to the needs of students with disabilities that I could attend.			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
					2 2 0 0 2 0	Always Sometimes Rarely Never Don't Know Does not Apply			
					1 0 0 1 4 0	P 63. My school district/charter school invites parents to trainings that are available to school staff regarding research based best practices, supplementary aids and services, differentiating instruction and modifying the general education curriculum. Always Sometimes Rarely Never Don't Know Does not Apply			
	N					18. FSA-SURROGATE PARENTS (STUDENTS REQUIRING) Standard: The LEA identifies eligible students in need of surrogate parents and recruits, selects, trains, and assigns in a timely manner.			
Y						19. FSA-PERSONNEL TRAINING Standard: In-service training appropriately and adequately prepares and trains personnel to address the special knowledge, skills, and abilities to serve the unique needs of children with disabilities, including those with low incidence disabilities, when applicable.			
						INTERVIEW RESULTS (General & Special Education Teacher)			
6	1	0				GE 88. Do you receive training regarding how to differentiate instruction and modify the curriculum in your classroom?			
6	1	0				GE 89. Do you receive training regarding how to provide positive behavior supports for students with negative behaviors?			
4	3	0				GE 90. If you have a student with a behavioral need, have you been trained how to deescalate negative and aggressive student behavior?			
7	0	0				GE 91. Do you participate in determining the kinds of training and technical assistance needed to support students with IEPs in regular education classrooms?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
0	0	7				GE 94. If a student has AT included in his/her current IEP, have you received training in AT, and accessing AT resources?			
6	1	0				SE 124. Do you collaborate with general education teachers and administrators to recommend training needs for personnel within the LEA?			
		X				20. FSA-INTENSIVE INTERAGENCY APPROACH Standard: The LEA identifies, reports, and provides for the provision of Free Appropriate Public Education (FAPE) for all students with disabilities including those students needing intensive interagency approaches.			
		X				21. FSA-SUMMARY OF ACADEMIC AND FUNCTIONAL PERFORMANCE/PROCEDURAL SAFEGUARD REQUIREMENTS FOR GRADUATION Standard: The LEA provides Summary of Academic Achievement and Functional Performance for children whose eligibility terminates due to graduation or aging out. The LEA provides required prior written notice for graduation			
	N					21A. TRANSITION REQUIREMENTS Standard: The LEA complies with requirements for transition planning for students.	The LEA has been provided with the names of individual students for whom corrective action is required.		
						Topical Area 2: Delivery of Service			
Y						17. FSA-PUBLIC SCHOOL ENROLLMENT Standard: The LEA's percentage of children with disabilities served in special education is comparable to state data.			
		X				17B. FSA-PUBLIC SCHOOL ENROLLMENT Standard: Timely provision of FAPE for students who transfer public agencies within state, and from another state.			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
Y						22. FSA-DISPROPORTIONATE REPRESENTATION THAT IS THE RESULT OF INAPPROPRIATE IDENTIFICATION Standard: LEA does not demonstrate disproportionate representation of racial/ethnic groups receiving special education or by disability group.			
	N					23. FSA-EDUCATIONAL BENEFIT REVIEW Standard: The IEP meets procedural compliance and is reasonably calculated to enable the child to advance appropriately toward attaining their annual goals.	The LEA has been provided with the names of individual students for whom corrective action is required within 30 days of the date of this report.		
						CLASSROOM OBSERVATIONS			
0	0	0		0		CO 1. Is the instruction provided to the student individualized as required by his/her IEP?			
0	0	0		0		CO 2. Is the instruction being provided in accordance with the goals in the student's IEP?			
0	0	0		0		CO 3. If assistive technology is included in the student's IEP and required for the activity observed, is it being used?			
0	0	0		0		CO 4. If the student is in a regular education setting, is he/she participating in the lesson taught by the general education teacher or a co-teacher?			
0	0	0		0		CO 5. If the student is in a regular education setting, is the student appropriately integrated (physically) in the class?			
0	0	0		0		CO 6. If the student's IEP contains supplementary aids and/or services, are they being delivered in the classroom setting as required?			
0	0	0		0		CO 7. Does this setting coincide with the student's IEP with regard to the extent to which the student is educated with non-disabled peers?			
						INTERVIEW RESULTS (Parent, General & Special Education Teacher)			
						P 55. My child does classroom work in a regular classroom with students without disabilities.			
					4	Always			
					0	Sometimes			
					0	Rarely			
					1	Never			
					1	Don't Know			
					0	Does not Apply			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
					5 1 0 0 0 0	P 56. My child participates or has the opportunity to participate in school activities other than classroom work, including extra-curricular activities, with students without disabilities. Always Sometimes Rarely Never Don't Know Does not Apply			
					3 1 0 2 0 0	P 56a. My child goes on field trips, attends school functions and/or participates in extracurricular activities with their same age/grade peers who are non-disabled. Always Sometimes Rarely Never Don't Know Does not Apply			
					3 2 0 0 0 1	P 56b. There are routine opportunities for my child to interact with peers who are non-disabled that are planned and/or facilitated by school personnel. Always Sometimes Rarely Never Don't Know Does not Apply			
7	0	0				GE 70. Are you familiar with the content of this student's current IEP, including accommodations, supplementary aids and services, and annual goals?			
6	0	1				GE 71. Do you adapt and modify the general education curriculum based on the student's current IEP?			
6	0	1				GE 72. Do you have support from special education personnel to help you modify curriculum, instruction and assessment as required in the student's current IEP?			
7	0	0				GE 73. Are you and the special education personnel working collaboratively to implement this student's program?			
7	0	0				GE 78. Are all the supplementary aids and services necessary for the student's progress in the general education class included in his/her current IEP?			
5	2	0				GE 80. Is the student making progress within the general education curriculum?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
5	2	0				GE 80a. In your opinion, is this student benefiting from participation in your general education classroom?			
0	0	2				GE 80b. If yes, in what ways? Performance has improved. Works better on assignments. Participates in class; earns bonus points. Able to be among a wider variety of students; exposed to challenging material. Doing well with the curriculum; gets to share ideas with peers. Participates in class, self confident, stable grades, no issues, great student.			
0	0	5				GE 80c. If no, what does this student need that he/she is not receiving in your class? Additional support. Attend school more regularly.			
5	2	0				GE 85. Do you have sufficient time to collaborate with the special education teacher in order to meet this student's needs?			
6	1	0				GE 85a. Have you received sufficient training, technical assistance and other support to teach this student?			
0	0	6				GE 85b. If no, what training or support would assist you? More discussion with the resource teachers.			
6	0	1				GE 93. Do special education personnel work directly with you to help you reduce negative student behaviors?			
7	0	0				SE 95. Is this student participating in the general education class and curriculum with students without disabilities to the maximum extent possible?			
2	1	4				SE 95a. In the most recent IEP meeting for this student, did you discuss whether he/she could be educated in a general education classroom for the entire school day?			
1	0	6				SE 95b. In the most recent IEP meeting, did the IEP team recommend removal of this student from the general education classroom for any part of the school day?			
0	0	6				SE 95c. If yes, what reasons were discussed for recommending removal? Need for service.			
0	0	6				SE 95d. If yes, how was the amount of time that this student would be removed from the general education classroom decided? IEP team.			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
3	0	4				SE 95e. In the most recent IEP meeting, did the IEP team discuss whether this student could be educated satisfactorily in a general education classroom for the entire school day with supplementary aids and services?			
7	0	0				SE 96. Has the student been given the opportunity to participate in non-academic and extracurricular activities with children without disabilities?			
6	0	1				SE 97. Have necessary supports been offered and/or provided to enable that participation?			
2	0	5				SE 99. Are you and related services personnel working together toward meeting the measurable annual goals for this student?			
7	0	0				SE 100. Are you and general education personnel working together toward meeting the measurable annual goals for this student?			
3	2	2				SE 115. Did the IEP team have available information regarding use of the Supplementary Aids and Services ToolKit?			
6	1	0				SE 125. Do you collaborate with general education teachers to identify training needs related to the provision of supplementary aids and services to students with IEPs in the general education classroom?			
						Topical Area 3: Performance Indicators			
		X				5A. FSA-EFFECTIVE USE OF DISPUTE RESOLUTION Standard: The LEA uses dispute resolution processes for program improvement.			
		X				6. FSA-GRADUATION RATES (SPP) Standard: The graduation rate of the LEA's students with disabilities is comparable to the state graduation rate.			
		X				7. FSA-DROPOUT RATES (SPP) Standard: The dropout rate of the LEA's students with disabilities is comparable to the state dropout rate.			
		X				8A. FSA-SUSPENSION RATES Standard: The LEA's rate of suspensions and expulsions of students with disabilities is comparable to the rate of other LEAs in the state.			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
Y						11. FSA-LEAST RESTRICTIVE ENVIRONMENT (SPP) Standard: Students with disabilities are provided for in the least restrictive environment			
		X				16. FSA-PARTICIPATION IN PSSA AND PASA (SPP) Standard: The LEA's population of students who participate in state assessment is comparable with the state data.			
		X				16A. FSA-LOCAL ASSESSMENT			
						Topical Area 4: Evaluation and Reevaluation Process and Content			
						CONSENT AND WAIVER REQUIREMENTS FOR EVALUATION/REEVALUATION			
						PERMISSION TO EVALUATE (File Reviews)			
0	1	9			100%	FR 153. PTE-Consent Form is present in the student file			
0	0	10				FR 154. Demographic data			
0	0	10				FR 155. Reason(s) for referral for evaluation			
0	0	10				FR 156. Proposed types of tests and assessments			
0	0	10				FR 157. Contact person's name and contact information			
0	0	10				FR 158. Parent signature or documentation of reasonable efforts to obtain consent			
0	0	10				FR 159. Parent has selected a consent option			
						PERMISSION TO REEVALUATE (File Reviews)			
6	2	2			25%	FR 194. PTRE-Consent Form is present in the student file			
6	0	4				FR 195. Demographic data			
6	0	4				FR 196. Reason for reevaluation			
6	0	4				FR 197. Types of assessment tools, tests and procedures to be used			
5	1	4			17%	FR 198. Contact person's name and contact information			
6	0	4				FR 199. Parent has selected a consent option			
6	0	4				FR 200. Parent signature or documentation of reasonable efforts to obtain consent			
						AGREEMENT TO WAIVE REEVALUATION (File Reviews)			
0	0	10				FR 201. Agreement to Waive Reevaluation is present in the student file			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
0	0	10				FR 202. Waiver was completed within required timelines (3 years (2 years for any ID student or any student placed in an Approved Private School) from date of ER, prior RR, or Agreement to Waive RR)			
0	0	10				FR 203. Reason reevaluation is not necessary at this time is included			
0	0	10				FR 204. Contact person's name and contact information			
0	0	10				FR 205. Parent has selected a consent option			
0	0	10				FR 206. Parent signature			
						EVALUATION REPORT (INITIAL) (File Reviews)			
1	0	9				FR 160. ER is present in the student file			
0	1	9			100%	FR 161. Evaluation was completed within timelines			
0	1	9			100%	FR 162. A copy of the ER was disseminated to parents at least 10 school days prior to meeting of the IEP team (unless this requirement is waived by parent in writing)			
1	0	9				FR 163. Demographic data			
1	0	9				FR 164. Date report was provided to parent			
1	0	9				FR 165. Reason(s) for referral			
1	0	9				FR 166. Reason(s) for referral reflect the reason(s) listed on the PTE-Consent Form			
1	0	9				FR 167. Evaluations and information provided by the parents of the student (or documentation of LEA's attempts to obtain parent input)			
1	0	9				FR 168. Teacher observations and observations by related service providers, when appropriate			
1	0	9				FR 169. Recommendations by teachers			
1	0	9				FR 170. The student's physical condition (including health, vision, hearing); social or cultural background; and adaptive behavior relevant to the student's suspected disability and potential need for special education			
1	0	9				FR 171. Assessments, including when appropriate, current classroom based assessments, aptitude and achievement tests; local and/or state assessments; behavioral assessments; vocational technical education assessment results; interests, preferences, aptitudes (for secondary transition); etc.			
1	0	9				FR 172. If an assessment is not conducted under standard conditions, description of the extent to which it varied from standard conditions (including if the assessment was given in the student's native language or other mode of communication)			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
1	0	9				FR 173. Lack of appropriate instruction in reading			
1	0	9				FR 174. Lack of appropriate instruction in math			
1	0	9				FR 175. Limited English proficiency			
1	0	9				FR 176. Present levels of academic achievement			
1	0	9				FR 177. Present levels of functional performance			
1	0	9				FR 178. Behavioral information			
1	0	9				FR 179. Conclusions			
1	0	9				FR 180. Disability Category			
1	0	9				FR 181. Recommendations for consideration by the IEP team			
0	1	9			100%	FR 182. Evaluation Team Participants documented			
0	0	10				FR 183. For students evaluated for SLD documentation of Agree/Disagree			
0	0	10				FR 184. Documentation that the student does not achieve adequately for age, etc.			
0	0	10				FR 185. Indication of process(es) used to determine eligibility			
0	0	10				FR 186. Instructional strategies used and student-centered data collected			
0	0	10				FR 187. Educationally relevant medical findings, if any			
0	0	10				FR 188. Effects of the student's environment, culture, or economic background			
0	0	10				FR 189. Data demonstrating that regular education instruction was delivered by qualified personnel, including the ESL program, if applicable			
0	0	10				FR 190. Data based documentation of repeated assessments of achievement at reasonable intervals, which was provided to parents			
0	0	10				FR 191. Observation in the student's learning environment			
0	0	10				FR 192. Other data if needed			
0	0	10				FR 193. Statement for all 6 items indicated to support conclusions of the evaluation team			
						REEVALUATION REPORT (File Reviews)			
9	0	1				FR 207. RR is present in the student file			
6	3	1			33%	FR 208. Reevaluation was completed within timelines (either 60 calendar days from the date of LEA receipt of signed PTRE-Consent Form, excluding summer break, or within 3 years (2 years for any ID student or any student placed in an Approved Private School) of date of ER, prior RR, or Agreement to Waive RR)			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
7	2	1			22%	FR 209. A copy of the RR was disseminated to parents at least 10 school days prior to the meeting of the IEP team (unless this requirement was waived by a parent in writing)			
9	0	1				FR 210. Demographic data			
7	2	1			22%	FR 211. Date IEP team reviewed existing evaluation data			
9	0	1				FR 212. Physical condition, social, or cultural background and adaptive behavior relevant to the student's need for special education			
9	0	1				FR 213. Evaluations and information provided by the parent (or documentation of LEA's attempts to obtain parent input)			
9	0	1				FR 214. Aptitude and achievement tests			
9	0	1				FR 215. Current classroom based assessments and local and/or state assessments			
9	0	1				FR 216. Observations by teacher(s) and related service provider(s) when appropriate			
9	0	1				FR 217. Teacher recommendations			
9	0	1				FR 218. Lack of appropriate instruction in reading			
9	0	1				FR 219. Lack of appropriate instruction in math			
9	0	1				FR 220. Limited English proficiency			
9	0	1				FR 221. Conclusion regarding need for additional data is indicated			
2	0	8				FR 222. Reasons additional data are not needed are included			
9	0	1				FR 223. Determination whether the child has a disability and requires special education			
9	0	1				FR 224. Disability category(ies)			
9	0	1				FR 225. Summary of findings includes student's educational strengths and needs			
9	0	1				FR 226. Summary of findings includes present levels of academic achievement and related developmental needs, including transition needs as appropriate			
9	0	1				FR 227. Summary of findings includes recommendations for consideration by the IEP team regarding additions or modifications to the student's programs			
7	0	3				FR 228. Interpretation of additional data			
4	0	6				FR 229. Documentation that the student does not achieve adequately for age, etc.			
4	0	6				FR 230. Indication of process(es) used to determine eligibility			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
4	0	6				FR 231. Instructional strategies used and student-centered data collected			
4	0	6				FR 232. Educationally relevant medical findings, if any			
4	0	6				FR 233. Effects of the student's environment, culture, or economic background			
4	0	6				FR 234. Data demonstrating that regular education instruction was delivered by qualified personnel, including the ESL program, if applicable			
4	0	6				FR 235. Data based documentation of repeated assessments of achievement at reasonable intervals, which was provided to parents			
3	1	6			25%	FR 236. Observation in the student's learning environment			
3	0	7				FR 237. Other data if needed			
4	0	6				FR 238. Statement for all 6 items			
7	2	1			22%	FR 239. Documentation of Evaluation Team Participants			
2	3	5			60%	FR 240. Documentation that team members Agree/Disagree			
						INTERVIEW RESULTS (Parent & Special Education Teacher)			
5	0	0	1			P 24. Have you been asked to provide information for your child's evaluation/reevaluation?			
4	0	1	1			P 25. Were you given the opportunity to provide this information in writing or in another way that worked for you?			
4	0	1	1			P 26. Was the information you provided to the school for your child's evaluation considered in your child's Evaluation Report?			
0	0	5	1			P 27. If your child was not reevaluated when required (every 2 years for children with intellectual disability (consent retardation), or any child placed in an Approved Private School, and every 3 years for children with other disabilities) did you agree in writing to waive the reevaluation?			
0	6	0	0			P 51. Have you requested an Independent Educational Evaluation (IEE) for your child to be paid for by the school?			
0	0	6	0			P 52. If you have obtained an IEE for your child, were the results of that evaluation considered by the team?			
0	0	6	0			P 53. Were the results of the IEE included in the school's Evaluation Report for your child?			
0	0	7				SE 119. If this student is not making progress, has he/she been reevaluated and/or has the IEP been reviewed?			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
						Topical Area 5: IEP Process and Content			
						INVITATION TO PARTICIPATE IN IEP TEAM OR OTHER MEETING (File Reviews)			
7	3	0			30%	FR 241. Invitation is present in the student file			
6	1	3			14%	FR 242. Invitation to Participate in the IEP Meeting was issued prior to the meeting (or documentation that parent signed waiver to move directly to IEP meeting)			
7	0	3				FR 243. Demographic data			
6	1	3			14%	FR 244. Purpose(s) of the meeting			
3	3	4			50%	FR 245. Transition planning and services – Invitation to parents is checked (age 14, younger if determined appropriate)			
2	1	7			33%	FR 246. Transition planning and services - if appropriate, evidence that a representative of any participating agency was invited to the IEP team meeting with the prior consent of the parent or student			
4	2	4			33%	FR 247. Transition planning and services – Invitation to student is checked (age 14, or younger if determined appropriate)			
6	1	3			14%	FR 248. Invited IEP team members			
7	0	3				FR 249. Date/time/location of meeting			
6	1	3			14%	FR 250. Parent response, or documentation of parent attendance at the meeting, or documentation of multiple efforts to encourage participation			
						PARENT CONSENT TO EXCUSE MEMBERS FROM ATTENDING IEP TEAM MEETING (File Reviews)			
0	0	10				FR 251. Parent Consent to Excuse Members from Attending the IEP Team Meeting is present in the student file			
0	0	10				FR 252. Demographic data			
0	0	10				FR 253. Form designates required IEP team member(s) for whom attendance is not necessary			
0	0	10				FR 254. Form designates which members will submit written input prior to the meeting			
0	0	10				FR 255. Parent written consent is documented			
					0	FR 256. The team members excused:			
					0	a. General Education Teacher			
					0	b. Special Education Teacher			
					0	c. Local Education Agency Representative			
						IEP CONTENT (File Reviews)			
10	0	0				FR 257. IEP is present in the student file			
6	4	0			40%	FR 258. IEP was completed within timelines			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
10	0	0				FR 259. Demographic data			
10	0	0				FR 260. IEP implementation date			
10	0	0				FR 261. Anticipated duration of services and programs			
2	1	7			33%	FR 262. If appropriate, LEA and parent agreement to make changes to IEP without convening an IEP meeting			
						DOCUMENTATION OF IEP TEAM PARTICIPATION (File Reviews)			
1	9	0			90%	FR 263. Parents			
0	6	4			100%	FR 264. Student			
0	10	0			100%	FR 265. General Education Teacher			
1	9	0			90%	FR 266. Special Education Teacher			
0	10	0			100%	FR 267. Local Education Agency Representative			
0	0	10				FR 270. Community Agency Representative			
0	0	10				FR 271. Teacher of the Gifted			
0	0	10				FR 272. Written input provided by IEP team member(s) excused from participating in the IEP meeting if the invitation stated they were to provide written input			
10	0	0				FR 273. Copy of Procedural Safeguards Notice was given to parent during the school year			
						SPECIAL CONSIDERATIONS (File Reviews)			
0	0	10				FR 274. If the student is blind or visually impaired, a description of the instruction in Braille and the use of Braille, unless the IEP team determines that such instruction is not appropriate			
0	0	10				FR 275. If the student is deaf or hard of hearing, a communication plan			
2	0	8				FR 276. If the student has communication needs, needs must be addressed in the IEP			
0	0	10				FR 277. If the student requires assistive technology devices and/or services, needs must be addressed in the IEP			
0	0	10				FR 278. If the student has limited English proficiency, the IEP team must consider English as Second Language for provision of FAPE			
1	0	9				FR 279. If the student has behaviors that impede his/her learning or that of others, the IEP includes a Positive Behavior Support Plan based on a functional assessment of behavior utilizing positive behavior techniques			
0	0	10				FR 280. If the student has other special considerations, these are addressed in the IEP			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
						PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE (File Reviews)			
9	1	0			10%	FR 281. Student's present levels of academic achievement			
9	0	1				FR 282. Student's present levels of functional performance			
5	1	4			17%	FR 283. Present levels related to current postsecondary transition goals (if student is 14, or younger if determined by IEP team)			
8	2	0			20%	FR 284. Parental concerns for enhancing the education of the student (if provided by parent to the LEA)			
8	2	0			20%	FR 285. How the student's disability affects involvement and progress in the general education curriculum			
10	0	0				FR 286. Strengths			
10	0	0				FR 287. Academic, developmental, and functional needs related to student's disability			
						TRANSITION SERVICES (File Reviews)			
4	2	4			33%	FR 289. Evidence that the measurable postsecondary goal(s) were based on age appropriate transition assessment			
4	2	4			33%	FR 290. An appropriate measurable postsecondary goal or goals that covers education or training, employment, and, as needed, independent living			
3	2	5			40%	FR 291. Evidence that the postsecondary goal or goals that covers education or training, employment, and, as needed, independent living are updated annually			
4	2	4			33%	FR 292. Location, Frequency, Projected Beginning Date, Anticipated Duration, and Person(s)/Agency Responsible for Activity/Service			
4	2	4			33%	FR 292a. Transition services include courses of study that will reasonably enable the student to meet his/her postsecondary goal(s)			
4	2	4			33%	FR 292b. Transition services in the IEP that will reasonably enable the student to meet his/her postsecondary goal(s)			
4	2	4			33%	FR 292c. Annual goals are related to the student's transition services			
						PARTICIPATION IN STATE AND LOCAL ASSESSMENTS (File Review)			
10	0	0				FR 293. Documentation of IEP team decision regarding participation in statewide assessments (PSSA/Keystone Exams, ACCESS for ELLS, Alternate ACCESS for ELLS or PASA)			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
8	0	2				FR 294. If the student will participate in the PSSA, documentation of IEP team decision regarding participation with or without accommodations			
0	0	10				FR 295. If the student will participate in the PASA, an explanation of why the student cannot participate in the PSSA/Keystone Exams			
0	0	10				FR 296. If the student will participate in the PASA, explanation of why PASA is appropriate			
0	0	10				FR 297. If the student will participate in the PASA, how student's performance will be documented (videotape or written narrative)			
9	0	1				FR 298. Indication of IEP team decision regarding participation in local assessments (local or alternate local)			
9	0	1				FR 299. If the student will participate in local assessments, indication of IEP team decision regarding participation with or without accommodations			
0	0	10				FR 300. If the IEP indicates the student will participate in an alternate local assessment, explanation of why the student cannot participate in the regular assessment			
0	0	10				FR 301. If the student will participate in an alternate local assessment, explanation of why the alternate assessment is appropriate			
						ANNUAL GOALS AND OBJECTIVES (INCLUDING ACADEMIC AND FUNCTIONAL GOALS) (File Reviews)			
9	1	0			10%	FR 302. Measurable Annual Goals			
9	1	0			10%	FR 303. Description of how student progress toward meeting goals will be measured			
10	0	0				FR 304. Description of when periodic reports on progress will be provided to parents			
10	0	0				FR 305. Documentation of progress reporting on Annual Goals			
1	0	9				FR 306. Short Term Objectives			
						SPECIAL EDUCATION/RELATED SERVICES/SUPPLEMENTARY AIDS AND SERVICES/PROGRAMS MODIFICATIONS (File Reviews)			
10	0	0				FR 307. Program Modifications and Specially-Designed Instruction			
9	0	1				FR 308. If the student's most recent Evaluation Report contained recommendations for modifications and accommodations, did the IEP team address those recommendations in development of this IEP			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
10	0	0				FR 309. If Program Modifications and Specially Designed Instruction are included on the IEP, the location, frequency, projected beginning date and anticipated duration of services			
0	0	10				FR 310. If a student attends a Career or Vocational Technical School, evidence that the specially designed instruction addresses the student's needs in Career and Vocational Technical School			
5	1	4			17%	FR 311. If Related Services are included on the IEP, the location, frequency, projected beginning date and anticipated duration of services			
4	1	5			20%	FR 312. If the student's most recent Evaluation Report contained recommendations for the provision of related services, including psychological counseling, did the IEP team address those recommendations in development of this IEP			
9	0	1				FR 313. If Supports for school personnel are included on the IEP, the personnel to receive support, support, location, frequency, projected beginning date and anticipated duration of services			
6	0	4				FR 314. If the student's most recent Evaluation Report contained recommendations for program modifications or supports for school personnel provided for the student, did the IEP team address those recommendations in development of this IEP			
0	0	10				FR 315. Support services, if the student is identified as gifted and also is identified as a student with a disability			
9	1	0			10%	FR 316. A conclusion regarding student eligibility for ESY			
10	0	0				FR 317. Information or data reviewed by the IEP team to support the ESY eligibility determination			
3	0	7				FR 318. Where ESY services were deemed appropriate, annual goals and when appropriate, short term objectives that are to be addressed in the child's ESY program			
3	0	7				FR 319. Where ESY was determined to be appropriate, ESY service to be provided, location, frequency, projected beginning date and anticipated duration of services			
						EDUCATIONAL PLACEMENT (File Reviews)			
8	2	0			20%	FR 320. Explanation of the extent, if any, to which the student will not participate with students without disabilities in the regular education class			

Y	N	NA	D K	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
8	2	0			20%	FR 321. Explanation of the extent, if any, to which the student will not participate with students without disabilities in the general education curriculum			
10	0	0				FR 322. Type of support, by amount (itinerant, supplemental, full-time)			
10	0	0				FR 323. Type of special education supports, e.g. autistic support, emotional support, learning support, etc.			
10	0	0				FR 324. Location of student's program (name of LEA where the IEP will be implemented)			
10	0	0				FR 325. Location of student's program (name of School Building where the IEP will be implemented)			
3	0	7				FR 326. If child will not be attending his/her neighborhood school, reason why not			
						PENNDATA REPORTING FOR EDUCATIONAL ENVIRONMENT (File Reviews)			
10	0	0				FR 327. Completed Section A or Section B			
						IEP DEVELOPMENT			
						INTERVIEW RESULTS (Parent & General Education Teacher)			
6	0	0	0			P 28. Were you invited to participate in your child's most recent IEP team meeting?			
6	0	0	0			P 29. Did you participate in developing the current IEP for your child?			
6	0	0	0			P 30. Was the meeting held at a time and location that was convenient for you?			
0	0	6	0			P 31. If you were unable to participate in person, did the school offer other arrangements for you to participate by phone or through other methods?			
6	0	0	0			P 32. Was the input you provided considered in the development of your child's current IEP?			
5	0	0	1			P 32a. Have you received sufficient training, technical assistance and other support to participate as an IEP team member?			
0	0	6	0			P 32b. If no, what training or support would assist you?			
2	0	4	0			P 33. Were the services you requested for your child considered by the IEP team in the development of your child's current IEP?			
5	1	0	0			P 35. Was the current IEP developed at the IEP meeting?			
6	0	0	0			P 36. If there was a draft IEP developed prior to the IEP meeting were you provided a copy of the draft either before or at the meeting?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
5	1	0	0			P 37. Were the special education teacher, the general education teacher and the school representative at the IEP meeting?			
0	0	6	0			P 38. If required IEP team members (special education teacher, general education teacher, or LEA) did not attend the meeting, did you agree in writing to them not being there?			
0	0	6	0			P 39. Was written input from the excused IEP team member(s) available to you before the meeting?			
		6	0			P 65. If you did not participate in your child's IEP meeting, what kept you from participating?			
5	0	2				GE 74. Did you attend the most recent IEP meeting for this student or have the opportunity to provide input?			
2	2	3				GE 75. Did you recommend any needed supports to implement the current IEP for this student?			
2	0	5				GE 76. Were those recommendations considered by the IEP team?			
7	0	0				GE 86. When a student with a disability is included in your class do you have the opportunity to provide information to the IEP team?			
6	1	0				GE 87. Do you provide progress monitoring data as part of the IEP development process?			
						IEP CONTENT			
						INTERVIEW RESULTS (Parent, General & Special Education Teacher)			
5	0	0	1			P 40. Did the IEP team consider the recommendations that were made in your child's most recent evaluation, including all recommendations that were made by the evaluation team for special education, related services, and supports for school personnel?			
5	0	0	1			P 41. Did the IEP team accept or reject the evaluation team's recommendations for special education, related services, and supports for school personnel for appropriate educational reasons.			
6	0	1				GE 81. Are this student's goals based on the PA Standards/PA Common Core or, if appropriate, alternate standards?			
7	0	0				GE 82. Is the specially designed instruction in this student's current IEP appropriate to meet his/her educational needs?			
7	0	0				GE 83. Is the current IEP appropriate to meet this student's educational needs?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
7	0	0				SE 98. Unless otherwise specified in the student's IEP, is the length of this student's instructional day the same as nondisabled students?			
6	0	1				SE 102. Is the specially-designed instruction in the current IEP appropriate to meet this student's educational needs?			
6	0	1				SE 103. Are the student's annual goals based on the PA Standards/PA Common Core or, if appropriate, alternate standards?			
5	0	2				SE 104. If appropriate, are the student's annual goals based on functional performance?			
5	0	2				SE 106. If the student's most recent Evaluation Report contained recommendations for modifications and accommodations did the IEP team address those recommendations in development of the student's current IEP and accept or reject the ER recommendations for appropriate educational reasons?			
3	0	4				SE 107. If the student's most recent Evaluation Report contained recommendations for provision of related services, including psychological counseling, did the IEP team address those recommendations in development of the student's current IEP and accept or reject the ER recommendations for appropriate educational reasons?			
5	0	2				SE 108. If the student's most recent Evaluation Report contained recommendations for program modifications or supports for school personnel that will be provided for the student, did the IEP team address those recommendations in development of the student's current IEP and accept or reject the ER recommendations for appropriate educational reasons?			
4	0	3				SE 112. Was it an IEP team decision as to whether this student would participate in the PSSA/Keystone Exams, PASA, and other district-wide/charter school-wide assessments?			
6	1	0				SE 117. Is this student making progress in meeting the annual goals of his/her current IEP?			
6	0	1				SE 117a. In your opinion, is this student benefiting from participation in the general education classroom?			
0	0	1				SE 117b. If yes, in what ways?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
						<p>Enjoys interaction with peers, feels successful and accomplishes work.</p> <p>Completes work.</p> <p>Making progress and doing well; gets to hear other students when ideas are shared.</p> <p>Making progress in the curriculum.</p> <p>Interacts with peers, exposed to and benefiting from relevant curriculum.</p> <p>Active in class and conversation, academic improvements, positive interactions with peers.</p>			
0	0	7				SE 117c. If no, what does this student need that he/she is not receiving?			
7	0	0				SE 118. Is the progress on annual goals recorded and reported to the parent based on objective and measurable data?			
						IEP IMPLEMENTATION			
						INTERVIEW RESULTS (Parent, General & Special Education Teacher)			
5	1	0	0			P 48. Were the special education and related services in your child's current IEP provided within 10 school days of the completion of the IEP?			
6	0	0	0			P 49. Are the special education and related services included in your child's current IEP provided at no cost to you?			
					4 1 0 0 1 0	<p>P 57. When all students in the school receive a report card, I also receive a progress report on my child's IEP goals.</p> <p>Always</p> <p>Sometimes</p> <p>Rarely</p> <p>Never</p> <p>Don't Know</p> <p>Does not Apply</p>			
					6 0 0 0 0 0	<p>P 58. My child's progress is reported to me by the school in a manner that I understand.</p> <p>Always</p> <p>Sometimes</p> <p>Rarely</p> <p>Never</p> <p>Don't Know</p> <p>Does not Apply</p>			
6	0	0	0			P 64. My child is receiving the supports and services agreed upon at the IEP meeting.			
7	0	0				GE 77. If supports for school personnel are included in the student's current IEP, has the LEA provided those supports?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
7	0	0				GE 79. Are the supplementary aids and services, including program modifications and specially designed instruction in the student's current IEP, being provided?			
3	1	3				GE 79a. In the most recent IEP meeting for this student, did you discuss whether the student could be educated in a general education classroom for the entire school day?			
1	3	3				GE 79b. In the most recent IEP meeting, did the IEP team recommend removal of this student from the general education classroom for any part of the school day?			
0	0	6				GE 79c. If yes, what reasons were discussed for recommending removal? Needed more instruction.			
0	0	6				GE 79d. If yes, how was the amount of time that this student would be removed from the general education classroom decided? IEP team.			
3	1	3				GE 79e. In the most recent IEP meeting, did the IEP team discuss whether this student could be educated satisfactorily in a general education classroom for the entire school day with supplementary aids and services?			
1	0	6				GE 84. If appropriate, are you implementing the positive behavior support plan for this student as written in the current IEP			
3	0	4				GE 92. If a student with an IEP is having behavioral difficulties in your classroom, do you address the behavior in your classroom rather than sending him/her back to the special education classroom to address the behavior issue unless indicated otherwise in the student's IEP?			
7	0	0				SE 105. Are the supplementary aids and services, including program modifications and specially designed instruction in the student's current IEP, being provided?			
7	0	0				SE 109. Is this student receiving the type and amount of special education instruction and related services specified in his/her current IEP?			
6	0	1				SE 110. Was this student's current IEP implemented no later than 10 school days after its completion or no later than the IEP implementation date?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
7	0	0				SE 111. If supports for school personnel are included in this student's current IEP, has the LEA provided those supports?			
5	0	2				SE 113. If required, were the testing accommodations included in this student's current IEP implemented?			
5	0	2				SE 114. Was the placement decision made by the IEP team after the annual goals, specially designed instruction, and related services were developed?			
7	0	0				SE 120. Is this student receiving the supports and services agreed upon in his/her current IEP, including related services?			
						PROVISION OF ESY AND RELATED SERVICES INTERVIEW RESULTS (Parent & Special Education Teacher)			
3	0	3	0			P 42. If your child's current IEP includes psychological counseling as a related service, and he/she receives these services, including transportation, are they provided at no cost to you?			
3	3	0	0			P 43. Was your child's need for extended school year (ESY) – which means services over the summer or during breaks from the regular school calendar - discussed at an IEP meeting?			
3	1	2	0			P 44. Did you receive an explanation of what would make your child eligible for ESY services?			
3	0	2	1			P 45. Did you agree with the IEP team's conclusion about your child's eligibility for ESY services?			
0	0	6	0			P 46. If you did not agree with the decision on ESY eligibility, were you given a written notice (NOREP/PWN) explaining that you could ask for a due process hearing?			
1	0	5	0			P 47. If your child was determined to be eligible for ESY services, did the IEP team decide upon the goals and services needed for the ESY program?			
5	0	2				SE 121. Was the consideration of ESY eligibility discussed during this student's current IEP meeting?			
1	0	6				SE 122. If this student was determined to be ESY eligible, did the IEP team determine what goals and services were needed and include them in the IEP?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
0	0	7				SE 122a. At the most recent IEP meeting, did the IEP team discuss the development of a plan to transition this student back into the school district (or charter school if student is enrolled in a charter school) with supplementary aids and services?			
0	0	7				SE 122b. Are staff from the home district (or charter school if student is enrolled in a charter school) involved with the planning and implementation of this student program?			
0	0	7				SE 122c. Does this student go on field trips, attend school functions or participate in extracurricular activities with his/her same age/grade peers who are non-disabled?			
0	0	7				SE 122d. Does this student need supplementary aids and services to participate in non-academic and/or extra-curricular activities?			
0	0	7				SE 122e. If yes, are needed supplementary aids and services being provided to this student?			
0	0	7				SE 122f. Are there routine opportunities for this student to interact with non-disabled peers that are planned and/or facilitated by school personnel?			
						SECONDARY TRANSITION (Parent & Special Education Teacher)			
3	0	3	0			P 50. If your child is age 14 or older was he/she invited to participate in the IEP meeting for transition planning?			
2	2	1	1			P 50a. In the most recent IEP meeting for your child, did you discuss whether your child could be educated in a general education classroom for the entire school day?			
1	2	2	1			P 50b. In the most recent IEP meeting, did the IEP team recommend removal of your child from the general education classroom for any part of the school day?			
0	0	5	0			P 50c. If yes, what reasons were discussed for recommending removal? The need for additional services.			
0	0	5	0			P 50d. If yes, how was the amount of time that your child would be removed from the general education classroom decided? IEP team.			
3	0	2	1			P 50e. In the most recent IEP meeting, did the IEP team discuss whether your child could be educated satisfactorily in a general education classroom for the entire school day with supplementary aids and services?			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
5	0	1	0			P 50f. In your opinion, is your child benefiting from participation in the general education classroom?			
0	0	1	0			P 50g. If yes, in what ways? No issues with peers, concentrates better, has a good knowledge base for content. Is motivated by being included in general education; is learning better. My child is learning. Does well in core content. Better grades, has made some friends, mostly likes school.			
0	0	6	0			P 50h. If no, what does your child need that he/she is not receiving in the class?			
					3 0 0 0 0 3	P 59. I am satisfied with the transition services developed for my child. Always Sometimes Rarely Never Don't Know Does not Apply			
					3 0 0 0 0 3	P 60. My child is learning skills that will lead to a high school diploma and further education and/or employment. Always Sometimes Rarely Never Don't Know Does not Apply			
3	0	4				SE 116. Were this student's desired post school outcomes considered when the IEP team developed the annual goals?			
5	0	2				SE 123. Where appropriate, does the LEA invite a representative of a participating agency that is likely to be responsible for providing or paying for transition services to the IEP meeting?			
						Topical Area 6: NOREP/PWN			
						(File Reviews)			
10	0	0				FR 328. NOREP/PWN is present in the student file			
10	0	0				FR 329. Demographic data			
10	0	0				FR 330. Type of action taken			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
9	1	0			10%	FR 331. A description of the action proposed or refused by the LEA			
9	1	0			10%	FR 332. An explanation of why the LEA proposed or refused to take the action			
9	1	0			10%	FR 333. A description of the other options the IEP team considered and the reason why those options were rejected			
10	0	0				FR 334. Description of each evaluation procedure, assessment, record or report used as the basis for proposed action or action refused			
6	0	4				FR 335. Description of other factor(s) relevant to LEA's proposal or refusal			
9	1	0			10%	FR 336. Educational placement recommended (including amount and type)			
9	0	1				FR 337. Signature of school district superintendent or charter school CEO or designee			
10	0	0				FR 338. Parent signature or documentation of reasonable efforts to obtain consent (e.g. mailed to parents, certified mail, visit to the parent's home, etc.)			
10	0	0				FR 339. Parent has selected a consent option			
9	1	0			10%	FR 340. NOREP/PWN reflects the educational placement indicated on the student's IEP			
						INTERVIEW RESULTS (Parent)			
0	0	5	1			P 34. If services that you requested for your child were rejected by the school, did you receive a written notice (NOREP/PWN) explaining why the request was rejected?			
						P 61. If I don't understand my child's educational rights, and I inquire about them, someone from the school takes the time to explain them to me.			
					5	Always			
					1	Sometimes			
					0	Rarely			
					0	Never			
					0	Don't Know			
					0	Does not Apply			
						Topical Area 7: Additional Interview Responses			
						INTERVIEW RESULTS (Parent & Special Education Teacher)			
						P 54. I am a partner with school personnel when we plan my child's education program.			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
					4 1 0 1 0 0	Always Sometimes Rarely Never Don't Know Does not Apply			
		0	0		2 1 1 1 3 1 1 1 1 1 3	P 66. Tell me anything you really like about your child's special education program. a. modifications c. staff-aide ratios d. staff's knowledge, training e. instructional materials g. staff open to suggestions, good communication h. follow the IEP i. support services j. student ratios k. staff's understanding and attitude n. other Teacher goes through the lessons with my child, understands the work and provides additional support when needed. Personalization of programming; pace of instruction so that my child has a solid understanding. The teachers take the time to get to know my child; is learning.			
		5	0		1	P 67. Tell me anything you would like to change about the program. n. other A core content class is difficult.			
		0	0		1 1 4	P 68. The school explains what options parents have if the parent disagrees with a decision of the school. a. Very strongly agree b. Strongly agree c. Agree			
						P 69. Additional comments about your child's program. My child is very happy and I am very happy.			
7	0	0				SE 101. Do you hold the required certification to implement this student's program?			
7	0	0				SE 101a. Have you received sufficient training, technical assistance and other support to teach this student?			
0	0	7				SE 101b. If no, what training or support would assist you?			
						Topical Area 8: Other Non-compliance Issues			
						Topical Area 9: Other Improvement Plan Issues			

Y	N	NA	DK	Not Obs	% #	Citation	Required Corrective Action Evidence of Change	Timelines and Resources	Closed Date
						FSA 15A Parent Survey Results	Based on the results of the parent survey, the LEA will submit an improvement plan to address parent trainings.		
						FSA 19A Teacher Survey Results	Since no teachers responded to the survey, the LEA will survey the teachers regarding their training needs and based on the results, submit an improvement plan to address teacher training.		



Insight PA Cyber Charter School
Special Education Agendas and Records of Staff and Parent Special Ed Trainings

Table of Contents:

1. 2017-2018 Special Ed Training Workbook
2. 2018-2019 Special Ed Training Workbook
3. Parent Training


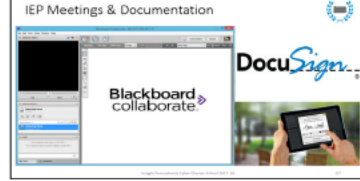


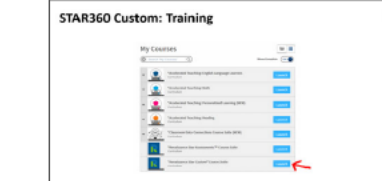
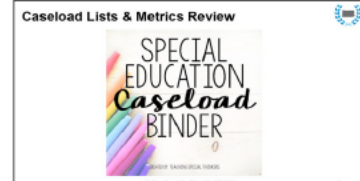



Special Education PD Date	Target Audience	Presenter(s)	Agenda Items Covered
9/7/2017	All Staff	Jen Jennings	Special Ed Dept Framework Overview of program/service delivery Related Services & Non-academic Supports IEP team meetings & documentation Q&A: Case Management
10/10/2017	SE Department	Jen Jennings	IEP Reviews Individualization & year over year updates Data-informed decision-making The PLAFFP section of the IEP Related Service & Academic Goals Staff input & ongoing cross-team consultations
12/1/2017	All Staff	Jen Jennings	IDEA overview of low(er) disability categories Focused review of Emotional Disturbance Emotional Disturbance vs. Socially Maladjusted Focused review of Other Health Impairment OHI definition, factors, & educational implications Focused review of Autism Autism definition, factors, & educational implications Focused review of Intellectual Disability Overview of high incidence disabilities Focused review of Specific Learning Disability SLD Eligibility: Historical model vs. best practice ISPA Evaluation Request Referral Form review
12/19/2017	SE Department		PowerSchool Login & Navigation Documentation for related service non-attendance Star360 Universal Screener overview Q&A: Consult on individual student or family cases
1/2/2018	SE Department	Jen Jennings	IEP Database System Setup & Logins Star360 Custom Training for Progress Measures Framework for Direct Instruction & Caseload Grouping Walk-through observations overview
2/23/2018	SE Department	Jen Jennings	Considerations when adopting prior IEP from in-state Initial IEPs for Newly Identified SWD ESY determinations & resources ESY vs. Summer School Procedures with finalized ER/RR reports

			PowerSchool import & migration updates
2/28/2018	All Staff	Jen Jennings	Behaviors that impede learning
			Disability categories & behavioral components
			Prevalence of "Behavioral" Disabilities at ISPA
			FAPE overview
			Section 504 vs. IDEA review
			Current ISPA student evaluation standings YTD
			Evaluation Process at ISPA
			Consent & Procedural Safeguards
			Related Service Coordination for ISPA Students
3/15/2018	SE Department	Jen Jennings	Standard Process for Annual IEPs - Pre vs. Post PowerSchool
			Guidelines for IEP Document Status - Draft vs. Final
			IEP Snapshots & Team Accessibility
			"Docs to File" Submissions & Standard ISPA Protocol
			Types of Support vs. Placement
			General Education Teacher Collaboration
5/4/2018	SE Department	Jen Jennings	Case Manager & Caseload Status Updates
			Updates for SE Teacher 1-on-1 Scheduling with SE Director
			ESY reviews, data, & recommendations from RS therapists
			Continuous oversight of caseload metrics with rolling enrollment
			IEPs to be completed prior to EOY
			New SE Teacher Support & Resources
5/11/2018	SE Department	Jen Jennings	Standard Sequence for IEP Team Meeting Logistics
			Special Considerations for Newly Identified Students
			Related service "Total Hours Owed"
			Related services & "Non-compliant" attendance status
			Barriers to RS delivery - Implications & Resolutions
			Documentation & communication if family refuses related service
			Overview of Therapist Coordination & Student Alignment
			Service invoicing & costs to ISPA for "No shows"
			10-day rule for IEP team review of RS non-attendance
6/11/2018	SE Department	Jen Jennings	EOY Teacher & Parent Input Requests
			All Docs to File Reminders & Target Date
			Overview of Summer Tasks & Needs
			Summer Team Availability Survey
			Prospective 18-19 Case Management Framework
			EOY Reflections
			18-19 Visions & Individual Wishes
			Logistical factors: Maintaining & Changing Needs

6/19/2018	SE Department	Jen Jennings	Enrollment processes & ways to improve efficiency Steps that may be unnecessary or confusing for larger team General parent inquiries & patterns of notification Anticipated updates for Family Connections & BOY steps Overview of Re-evaluation & Initial Evaluation Essentials PDE Evaluation Timelines Psychometric Assessments & Types Functional assessments & implications for evaluations
8/27/2018	All Staff	Jen Jennings	Special Ed "Ettiquette" & People-first Language Updates in SE Case Mangement Staffing & Framework New Support for Specialty Areas CMCI Introduction & Overview Staff Expectations for CMCI - Interviews & Surveys Access to Student IEPs & Updates to Snapshots General Communication Path for SE Dept Inquiries
8/28/2018	All Staff	Jen Jennings & Tony Grande (Lead Psych)	ISPA Student evaluation request referral process Enrollment portal & Child Find queries Systems Factors Contributing to Status Indicator Changes General guidance for clarifying parental concerns Considerations of prior educational history on performance Overview of Ability vs. Achievement Description of sequence & 3rd party logistics during 60-day window Eligibility determination & implications for supports & programming Evaluation Team Roles & Points of Contact
9/28/2018	SE Department	Jen Jennings & Shawna Briggs (RS Coordinator)	Basics of IEP Types & Purposes for IEP Meetings Connection between ER/RR-IEP-NOREP documents Special Considerations page of IEP - "The 'Yes' Plans" LRE Considerations - Incoming IEPs vs. New Annual IEPs Statements & Improving Language in Present Levels Summaries Caution about complex IEP goals & Goal Attack Activity Progress monitoring & reporting updates Demonstration of Related Service Manager database system RS Updates & Messaging
10/5/2018	LEAs	Jen Jennings	LEA scheduling for IEP meetings Process expectations for parent cancellations and no-shows Standard CM process for setting up virtual IEP team meeting Expectations for GE Teacher inclusion & involvement Follow-up IEP meeting process - rescheduling & LEA verifications
			IEP meeting attempts & rescheduling - protocols & red flags

10/25/2018	SE Department	Jen Jennings	Scheduling Attempts & IEP Meeting Invitation Forms
			Decision-tree according to Parent/LG response to Invitation
			IEP Meeting & Document Date Clarification of Compliance
			Case manager steps following IEP meeting
			Process for Finalizing & Submitting all IEP Meeting Documents
			Verification of steps for sending finalized IEP documents to family
			Reminders about updating IEP Snapshots for GE accommodations
			Positive & Factual Language in IEPs
			Reducing Subjective or Ambiguous Language to Enhance IEPs
11/2/2018	Student Support Services Team	Jen Jennings	Current ISPA Disability Breakdown by Count
			Standings of Initial Evaluations completed by ISPA YTD
			Considerations for preventing overidentification of SLD
			Educational & Ecological Factors Impacting Student Learning
			Exclusionary Factors for Determining SLD
			How evaluators utilize MTSS/Intervention data in evaluations
11/7/2018	ISPA Family Session	Jen Jennings	Special Education Format & Terms @ ISPA
			Instructional Delivery with Continuum of Supports
			Department titles & duties
			Home-based Student Data for Input
			Cyclical Monitoring Overview
			Target Dates & Anticipated Steps for Parent Surveys
			Description of CMCI Survey Items
General Steps Following CMCI per Bureau of Special Ed Guidelines			
1/30/2019	SE Department	Jen Jennings	Case Management Framework/Assignments Updates
			Staffing Changes with New SE Teachers Hired
			Review of MS/HS Schedules for SE Case Management
			Quarterly Progress Reports Communications & Deadlines
			PASA Assessment Support Needs
			PSSA Accommodations
			Notification re: Board-appointed SE Program Auditor
			Instructional Coaching Opportunities for SE Teachers
3/4/2019	SE Teams by Grade Band	Jen Jennings	Updated Standard Protocols for IEP Team Meeting Coordination
			Demo: Calling Parents Directly from BBC Meeting Room
			3 upcoming asynchronous SE trainings
			RS Updates & Messaging
			Individual CM consultations on complex student profiles
3/18/2019	SE Teams by Grade Band	Jen Jennings	IEP Meeting Facilitation - Setting Tone & Context for Team
			IEP Meeting preparation checklist & considerations
			Updates for Coordinating IEP Meeting Date & LEA Assignments

			Document Exchange Protocols for IEP Meeting Participants IEP Introduction re: Type of Meeting & Items to Cover with Team
4/4/2019	SE Department	Kimberly Colonna, Esq. (ISPA Solicitor)	PRESENTATION TITLE: "Common IEP Mistakes and How to Avoid Them"
4/29/2019	SE Department	Jen Jennings & Shawna Briggs (RS Coordinator)	New Support Staff Introduction Updated SE Department Framework Overview of Open Positions on Special Education Team ESY Service Referrals & Caseload Metrics Tracker Documentation How To: Submitting Requests for Specialized Equipment Summer Team Availability Survey Notice EOY Tasks for Caseload Organization & Readiness for SY19-20

Date of PD	PD Slide Samples																							
9/7/2017	<p>Background information</p> 	<p>Considerations of Adequate Instruction</p> <ul style="list-style-type: none"> History of testing/testing/peer conflicts History of extensive truancy Significant medical issues Dissatisfaction with prior school/instruction Dissatisfaction with previous special ed supports History of classroom behavior concerns Changes in school zoning, charter school closures 	<p>Home & Staff Input – Qualitative Data</p> <p>Home-based data</p> <ul style="list-style-type: none"> Observations from parents/guardians Self-reports from student Increase of desired skills? Decrease of undesired behaviors? <p>School-based data</p> <ul style="list-style-type: none"> Student's performance when engaged in other classes Application of skills in other classes Patterns of inconsistency? Independent use of resources or technology to perform tasks? 	<p>IEP Meetings & Documentation</p> 																				
10/10/2017	<p>CONSIDERING THE INCOMING IEP</p> <p>WHAT OTHERS ARE SAYING...</p> <p>Analyze Prior Info</p> <p>Consider what items may appear to be repeated/ongoing</p> <ul style="list-style-type: none"> What deficits are noted/indicated as barriers to learning? What strategies have worked? Which annual goals appear to not have been met? Which annual goals were progressing appropriately? What adjustments can we make to change our approach to working on a skill deficit? 	<p>CONSIDER GOALS TO BE MEASURED</p> <ul style="list-style-type: none"> Academic Goals Related Service Goals  <p>Goals that create the educational program for the child in order for them to achieve academic growth.</p> <p>Goals set to support the child to be able to access special education services, Related services SUPPORT systems.</p>	<p>CONSIDER PRESENT LEVELS</p> <p>PRESENT LEVELS OF PERFORMANCE</p> <ul style="list-style-type: none"> Eligibility information Information regarding team/program/services Summary of current work: <ul style="list-style-type: none"> Reading and math assessments Current grades Observed skills/utilization of supports Behavioral referrals Records of work habits. 																					
12/1/2017	<p>Emotional Disturbance</p> <p>Emotional Disturbance</p> <ul style="list-style-type: none"> Unable to comply with requests; needy; difficulty asking for help Misses school due to emotional or psychosomatic issues Uneven achievement due to impaired anxiety, depression, or emotions Poorly developed social skills; immature; difficulty with social cues <p>Socially Maladjusted</p> <ul style="list-style-type: none"> Unwilling to comply with requests; truancy; refuses help Misses school due to choice issues Achievement influenced by truancy, negative attitude toward school, avoidance Well-attuned to social skills; may associate with 	<p>High Incidence Disability Factors</p> <p>Limitations to the 'test-score discrepancy model':</p> <ul style="list-style-type: none"> Requires chronic school failure BEFORE remedial/special education supports can be given Fails to consider that outside factors such as gaps in instruction that may contribute to a child's learning delay. A severe discrepancy provides no useful information about why the student is doing poorly academically. Often different formulas are used by States and districts to diagnose LD, resulting in a lack of uniformity in classification. 	<p>High Incidence Disability Factors</p> <p>The tree of specific learning difficulties</p> 	<p>REQUESTS FOR EVALUATIONS</p> <p>INSIGHT PA Special Ed Evaluation Request Form</p> <p>Family-Initiated Referral</p> <p>Live Survey Link</p>																				
1/10/2018	<p>POWER SCHOOL LOGINS</p> <p>Landing Page</p> 	<p>STAR360 Custom: Training</p> 	<p>Caseload Lists & Metrics Review</p> <p>SPECIAL EDUCATION Caseload BINDER</p> 																					
2/23/2018	<p>IEPs - Newly identified</p> <ul style="list-style-type: none"> Upon completion sent to SE teacher from Rachel Wise SE teacher uploads to PowerSchool as an attachment IEP generated from ER (Out of state or general ed) High priority NOREPs – Encourage printing/scanning back For initial SE determination, SD should not begin until signed NOREP received 	<p>Post-IEP collaboration & communication</p> <p>Regular Team Communication Step Needs:</p> <p>Copy general ed teachers on email to Parents/IG with finalized IEP & meeting docs attached</p>  <p>Reminder: Set the IEP document Status to Final in PowerSchool to remove the watermark & update teacher BIRCEB sending to parent/IG and Docs to File</p>	<p>ESY determination – PDE outline & Caseload</p> <p>Extended School Year (ESY)</p> <ul style="list-style-type: none"> If ESY was previously recommended, ok to maintain on new IEP if insufficient time/participation to rule out continued need. New recommendations for ESY must only be made with the state-determined decision process Resource: ESY Teachers' Desk Reference added to SharePoint (Special Ed Resources & Guides folder) FYI - ESY indicator captured under "Services" section of IEP menu in PowerSchool To Be Determined - Specific ESY dates & framework for SMP 																					
2/28/2018	<p>Highlighting "Behavioral" Disabilities – Solely for the purposes of this topic</p> 	<p>Current "Behavioral" Disabilities</p> <p>Percentages of Total</p> <table border="1"> <thead> <tr> <th></th> <th>TOTAL STUDENTS</th> <th>ED</th> <th>OHI</th> <th>Autism</th> </tr> </thead> <tbody> <tr> <td>K-5 Total</td> <td>30%</td> <td>11%</td> <td>23%</td> <td>11%</td> </tr> <tr> <td>MS Total</td> <td>43%</td> <td>10 + 4</td> <td>16 + 4</td> <td>6 + 1</td> </tr> <tr> <td>HS Total</td> <td>26%</td> <td>5 + 1</td> <td>7 + 2</td> <td>0</td> </tr> </tbody> </table>		TOTAL STUDENTS	ED	OHI	Autism	K-5 Total	30%	11%	23%	11%	MS Total	43%	10 + 4	16 + 4	6 + 1	HS Total	26%	5 + 1	7 + 2	0	<p>504 Vs. IDEA</p> <p>Definitions of Disability: Section 504 and the IDEA include different definitions of "disabilities" or "disabling conditions."</p> <p>IDEA includes 13 categories of disabilities and lists the specific eligibility criteria for each category.</p> <p>Additionally, in order for a student to qualify under IDEA, the disabling condition must result in a need for special education and related services.</p>	<p>Evaluation Process</p> 
	TOTAL STUDENTS	ED	OHI	Autism																				
K-5 Total	30%	11%	23%	11%																				
MS Total	43%	10 + 4	16 + 4	6 + 1																				
HS Total	26%	5 + 1	7 + 2	0																				

3/15/2018

Annual IEPs (any type – post 2/26)

- All generated in PowerSchool format
- Import for all meetings after 2/26

Types of Supports vs. Placement

3. Type of special education supports

- Academic Support
- Behavioral Support
- Instructional Support
- Learning Support
- Life Skills Support
- Physical Support
- Speech and Language Support

General Ed Teacher Consult/Collabo

- Accommodations/Modifications
- IEP connection needs
- IEP Snapshots – ISPA SP site

Blank slide

5/4/2018

CASELOADS & WHO'S WHERE?

Caseload	Team Member
K-2	Kim Kohler (Lien Russell)
3-5	Nancy Orflett
6-7	Christan Garrison
8	Nancy Orflett (Kim Kohler)
9	Jamie Gittinger
10	Kathia Moyer
Life Skills	Anelesse Simon
Special Populations	Kathia Moyer (Projected)

STUDENT RECORDS & NEW SERVICE NEEDS

- Larger team meeting scheduled with Operations & Registrar
- Transitioning ROR process
- ESY review
- Providing compliance dates approaching 17-18
- Next report date – Sep/Oct 2018 for annual review/RR data collection
- IEP drafts opened in PE (new enrollments)
- Up ahead – Regular Special Ed data report at EPA Board Meetings

I-ON-I MEETINGS RE: SE COMPLIANCE (VOTE)

- Framework – IEP spot checks, QA guidance, specific student needs, process/timeline
- Frequency Preference (local)
- Day/Time Slots (initial)

	Monday	Wednesday	Friday
10:00	11:00	1:00	
11:30	11:30	1:00	
12:30	12:00	2:30	
1:00			

INDIVIDUAL RESOURCE ACCESS NEEDS

- INIGHT FVETBERANS...** You're free to jump into your next work activity of the day!
- NEW FOLKS...** Please stay in the room so we can go through systems and resources.

New logins & access barriers?




5/11/2018

17-18 Enrollment Pulse Check

Strat	Current Count	Today's Update
Interim	89	0
Midline	89	0
High	44	2

- Source – Total/View Enrollment
- Lighter Monday "New Starts"
- Intent to re-register


"Special Care" for Newly Identified



- Evaluation Report (ER) reviewed with parent PRIOR TO initial IEP meeting – if not, must be reviewed or meeting
- "SCHOOLING AND PROCEED" – For "initial provisions," we'd try to try 3 to 30 attempts if needed
- Parent/IG CAN give consent to proceed with meeting if they have reviewed everything and agree with findings
- Can be noticed by parent on invite

Related Services & "Non-compliant" Status

SITUATION: You are receiving emails from Shyama, showing that a therapist is observing a pattern of missed therapy sessions




Related Services & "Non-compliant" Status

- IMPLICATION:** This is documented as a "non-compliant" to the implementation of a service (SPA is required to implement), per the IEP
- Parent contact:** – Connect to find out what may be the issue (scheduling/technology/format) and ultimately see if they confirm/deny/agree to coordinate for scheduled therapy sessions. Follow-up with Shyama
- No Parent contact:** – Email & VVA still no response... Send invite to IEP revision: "Hold" revision when YOU can (if still no response)


6/11/2018

Summary of Summer

- Transfer IEP Reviews (Adopt or Hold)
- Student support groupings
- New IEP Development (Reviewing, evaluation)
- In-office file support (WIS/New/Updates)
- Data entry
- Document migration
- Parent welcome call & script



End of Year Special Ed PD




How might we

- Enhance our communications & processes...
- New student enrollment
- Changes in service
- Low/No engagement
- Therapist involvement
- Assistive technology resources
- Progress monitoring
- IEP coordination & expertise
- SD framework & schedule

18-19 Caseload Arrangements

- Type of Support (Academic vs. Functional)
- Level of Support (Amount outside Gen Ed – IRE)
- Kindergarten & HS Transition Supports
- Life Skills
- Special populations & complex profiles



Blank slide

6/19/2018

REFLECTIONS & VISIONS

FOR YOU FOR THE TEAM FOR YOUR STUDENTS



18-19 ENROLLMENT BATON RELAY

Steps that... worked, helped, improved, made sense



Steps that... confused, delayed, seemed silly


18-19 Enrollment Baton Relay Process



8/27/2018

TOSSING OUT SOME SPECIAL ED MISNOMERS

- AVOID THE ADJECTIVE... SPECIAL ED DOESN'T DESCRIBE THE STUDENT
- PEOPLE FIRST – STUDENTS WITH... DISABILITIES OR STUDENTS RECEIVING SPECIAL ED



MORE SPECIALTY AREAS OF FOCUS!

- LIFE SKILLS – ESMS CASELOAD & HS CASELOAD
- BEHAVIORALISM (INTENSIVE NEEDS)
- STAFF SCHOOL PSYCHOLOGIST – AND 2 SUPPORT PSYCHS
- POST-SECONDARY TRANSITION
- PRE-REFERRAL INTERVENTIONS (ACADEMIC & BEHAVIORAL)

CMGI – SPECIAL ED AUDIT

- BUREAU OF SPECIAL EDUCATION (BSE)
- AGE EVERY 5-6 YEARS
- SURVEYS FOR SE TEACHERS, GE TEACHERS, FAMILIES & STUDENTS (TRANSITION)
- INSTRUCTIONAL NEEDS & COMPLIANCE




Initial Enrollment Portal Entry



Ability vs. Achievement


PROFESSIONAL NOTE: One approach to monitor the health of our students.



Information from YOU



ISPA Special Education Evaluation Team, Links, & Contacts



<p>8/28/2018</p>				<p>Sharon Briggs – Related Services Coordinator; processes all evaluation referrals for all ISPA students Email – lspecialservices@132.org Link to Special Ed Referral Request Web Form (For ISPA Staff ONLY) – to be completed on behalf of a family, not to be completed by the family Survey Form For Evaluation Requests</p>
------------------	--	--	--	---

<p>9/28/2018</p>	<p>IEP Types & Purposes of Meetings</p>	<p>Notice of Recommended Educational Placement (NOREP)</p> <ul style="list-style-type: none"> Identification <ul style="list-style-type: none"> Initial categorical identification Change in categorical identification Termination of categorical identification Placement <ul style="list-style-type: none"> Initial placement determination Change to least restrictive environment along the continuum of placement alternatives 	<p>Goal Attack Practice</p> <p>3 Primary Questions to Ask:</p> <ul style="list-style-type: none"> Does the goal tell us what the student will specifically DO within 1 year? Can I measure this based on the criteria I've proposed? What data source would I rely on in order to know if progress is being made? <p>Overall Question: Is this a feasible ANNUAL goal tied directly to a current need specified in Present Levels?</p>	<p>Goal Attack Practice</p> <p>Below will participate in class when asked 80% of the time during a school week as measured by teacher observation.</p> <p>What will Below DO by this time next year? Can we measure 80% attendance over a week time frame? What data source would we rely on for this goal? Is this goal feasible as an annual goal? Why or why not?</p>
------------------	---	---	---	---

<p>10/5/2018</p>	<p>IEP Meeting Logistics</p> <ul style="list-style-type: none"> All now shared with Tracy to coordinate and prevent conflicts Finalized "1 week out," yet frequent parent cancellations/no-shows Standard set up – BBC AND Conference Line (Barriers/Tiny caveats...) All GE teachers invited; Best practice for ALL available to participate even when only 1 required If parent hasn't confirmed within 24-hours of 1st proposed date – SE teacher CANCELS invite and sends team + parent 2nd attempt invite; 	<p>High Stakes & Escalation Points</p> <ul style="list-style-type: none"> Obvious ones – Parent advocate/attorney; partial hospitalization; Initial evaluations ISPA conducts Parent disputes Verified truancy patterns Requests for specific curricular program or AT device (New) Reference to "looking at" alternate/non-public school 	
------------------	--	---	--

<p>10/25/2018</p>	<p>IEP Meeting "Attempts"</p> <ul style="list-style-type: none"> If the parent DOES confirm, but does not show by 10 minutes after the meeting time attempt to call parent in (see Case Manager Resource folder for instructions on conferencing from desk phone) If parent DOES NOT answer, excuse the team and consider that an IEP Meeting "Attempt" If parent DOES answer and cannot join for any reason, see if they would prefer the team reschedule or if they'd approve for the team proceed with holding the meeting (it's their right to participate) 	<p>Positive Language Throughout!</p> <p>PROGRESS NOTES/PRESENT LEVELS</p> <p>Be specific!</p> <p>"Student has attended ___ out of ___ sessions with SE teacher..."</p> <p>"Student participates in classes but has difficulty completing assignments..."</p> <p>"Student requires modifications to ___ in order to be more successful..."</p>	<p>Accommodations</p> <p>Things to think about...</p> <ul style="list-style-type: none"> How long will the student require this accommodation? How will I fade the use of the accommodation? Will the student always need this accommodation? i.e. think about wearing glasses. 	
-------------------	--	--	--	--

<p>11/2/2018</p>	<p>Total Students with Disabilities Approved - 379 (1V1)</p> <p>Initial evaluation – (General education) 40 initial student evaluations for 18-19 so far About half carried over Other half in progress at various points (including pending consent)</p>	<p>Considerations about a HIGH prevalence of "At-risk" student population</p>	<p>Exclusionary Factors</p> <ul style="list-style-type: none"> Environmental or economic disadvantage, or cultural factors Lack of appropriate instruction in reading, math or any other areas of SLD being considered Limited English proficiency Other impairments
------------------	--	---	---


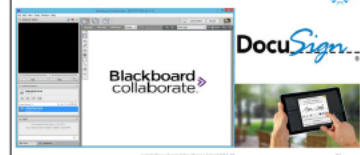


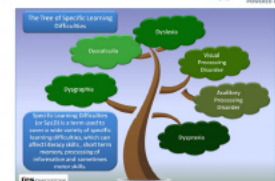

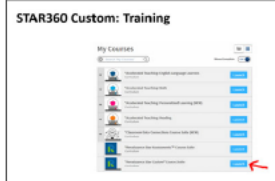
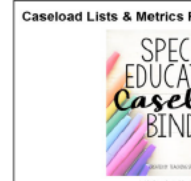



<p>11/7/2018</p>	<p>Special Education Department Framework</p> <p>Special Education Teachers</p> <ul style="list-style-type: none"> serve as "Case Managers" to guide instructional accommodations & modifications IEP oversight (writing & coordinating team meetings) Specialty designed instruction Co-teaching in GE courses or Small group/1:1 sessions Progress monitoring on IEP goals Point of contact for families & IEP team members 	<p>Cyclical Monitoring – Interviews & Surveys</p> <p>April 2019 – ISPA's Cyclical Monitoring by BSE</p> <p>Parent Surveys – Gathering broad feedback from ISPA families, to be disseminated by ISPA in new few weeks!</p> <ul style="list-style-type: none"> Target list of student files to be reviewed (30 files or 10%) ISPA receives this list from BSE approx. 30 days prior to monitoring BSE will contact families of target student list to conduct a structured interview General & Special Education teachers of target student list have a interview as well 	<p>Cyclical Monitoring – Survey Item Description</p> <ul style="list-style-type: none"> Knowledge of child's disability Understanding of type & amount of special education supports Awareness of child's participation in general education classes Level of agreement/disagreement on aspects of child's program & overall satisfaction with school-based team's efforts
------------------	---	---	--









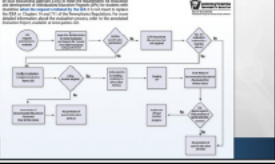


<p>Updates to Case Manager Framework</p> <p>High (9-11)</p> <ul style="list-style-type: none"> 9th Grade – Jen Weimer (PM: Math) – Itinerant 9th Grade – Lisa Young (PM: ELA) – Itinerant 	<p>PASA Assessor Support</p>	<p>PSSA Accommodations</p> <ul style="list-style-type: none"> Targeting "routinely used" for State assessments Considerations for "small group" & "Read-aloud" Considerations for students with low/no-engagement
---	------------------------------	--

Special Education PD Date	Target Audience	Presenter(s)	Agenda Topics Covered
9/7/2017	All Staff	Jen Jennings	Special Ed Dept Framework Overview of program/service delivery Related Services & Non-academic Supports IEP team meetings & documentation Q&A: Case Management
10/10/2017	SE Department	Jen Jennings	IEP Reviews Individualization & year over year updates Data-informed decision-making The PLAFFP section of the IEP Related Service & Academic Goals Staff input & ongoing cross-team consultations
12/1/2017	All Staff	Jen Jennings	IDEA overview of low(er) disability categories Focused review of Emotional Disturbance Emotional Disturbance vs. Socially Maladjusted Focused review of Other Health Impairment OHI definition, factors, & educational implications Focused review of Autism Autism definition, factors, & educational implications Focused review of Intellectual Disability Overview of high incidence disabilities Focused review of Specific Learning Disability SLD Eligibility: Historical model vs. best practice ISPA Evaluation Request Referral Form review
12/19/2017	SE Department		PowerSchool Login & Navigation Documentation for related service non-attendance Star360 Universal Screener overview Q&A: Consult on individual student or family cases
1/2/2018	SE Department	Jen Jennings	IEP Database System Setup & Logins Star360 Custom Training for Progress Measures Framework for Direct Instruction & Caseload Grouping Walk-through observations overview
2/23/2018	SE Department	Jen Jennings	Considerations when adopting prior IEP from in-state Initial IEPs for Newly Identified SWD ESY determinations & resources

2/29/2018	SE Department	Jen Jennings	ESY vs. Summer School Procedures with finalized ER/RR reports PowerSchool import & migration updates
2/28/2018	All Staff	Jen Jennings	Behaviors that impede learning Disability categories & behavioral components Prevalence of "Behavioral" Disabilities at ISPA FAPE overview Section 504 vs. IDEA review Current ISPA student evaluation standings YTD Evaluation Process at ISPA Consent & Procedural Safeguards Related Service Coordination for ISPA Students
3/15/2018	SE Department	Jen Jennings	Standard Process for Annual IEPs - Pre vs. Post PowerSchool Guidelines for IEP Document Status - Draft vs. Final IEP Snapshots & Team Accessibility "Docs to File" Submissions & Standard ISPA Protocol Types of Support vs. Placement General Education Teacher Collaboration
5/4/2018	SE Department	Jen Jennings	Case Manager & Caseload Status Updates Updates for SE Teacher 1-on-1 Scheduling with SE Director ESY reviews, data, & recommendations from RS therapists Continuous oversight of caseload metrics with rolling enrollment IEPs to be completed prior to EOY New SE Teacher Support & Resources
5/11/2018	SE Department	Jen Jennings	Standard Sequence for IEP Team Meeting Logistics Special Considerations for Newly Identified Students Related service "Total Hours Owed" Related services & "Non-compliant" attendance status Barriers to RS delivery - Implications & Resolutions Documentation & communication if family refuses related service Overview of Therapist Coordination & Student Alignment Service invoicing & costs to ISPA for "No shows" 10-day rule for IEP team review of RS non-attendance
6/11/2018	SE Department	Jen Jennings	EOY Teacher & Parent Input Requests All Docs to File Reminders & Target Date Overview of Summer Tasks & Needs

			Summer Team Availability Survey
			Prospective 18-19 Case Management Framework
6/19/2018	SE Department	Jen Jennings	EOY Reflections
			18-19 Visions & Individual Wishes
			Logistical factors: Maintaining & Changing Needs
			Enrollment processes & ways to improve efficiency
			Steps that may be unnecessary or confusing for larger team
			General parent inquiries & patterns of notification
			Anticipated updates for Family Connections & BOY steps
			Overview of Re-evaluation & Initial Evaluation Essentials
			PDE Evaluation Timelines
			Psychometric Assessments & Types
			Functional assessments & implications for evaluations
8/27/2018	All Staff	Jen Jennings	Special Ed "Etiquette" & People-first Language
			Updates in SE Case Management Staffing & Framework
			New Support for Specialty Areas
			CMCI Introduction & Overview
			Staff Expectations for CMCI - Interviews & Surveys
			Access to Student IEPs & Updates to Snapshots
General Communication Path for SE Dept Inquiries			

Date of PD	PD Slide Samples																							
9/7/2017	<p>Background information</p> 	<p>Considerations of Adequate Instruction</p> <ul style="list-style-type: none"> History of testing/testing/peer conflicts History of extensive truancy Significant medical issues Dissatisfaction with prior school/instruction Dissatisfaction with previous special ed supports History of classroom behavior concerns Changes in school zoning, charter school closures 	<p>Home & Staff Input – Qualitative Data</p> <p>Home-based data</p> <ul style="list-style-type: none"> Observations from parents/guardians Self-reports from student Increase of desired skills? Decrease of undesired behaviors? <p>School-based data</p> <ul style="list-style-type: none"> Student's performance when engaged in other classes Application of skills in other classes Patterns of inconsistency? Independent use of resources or technology to perform tasks? 	<p>IEP Meetings & Documentation</p> 																				
10/10/2017	<p>CONSIDERING THE INCOMING IEP</p> <p>WHAT OTHERS ARE SAYING...</p> <p>Analyze Prior Info</p> <p>Consider what items may appear to be repeated/ongoing</p> <ul style="list-style-type: none"> What deficits are noted/indicated as barriers to learning? What strategies have worked? Which annual goals appear to not have been met? Which annual goals were progressing appropriately? What adjustments can we make to change our approach to working on a skill deficit? 	<p>CONSIDER GOALS TO BE MEASURED</p> <ul style="list-style-type: none"> Academic Goals Related Service Goals  <p>Goals that create the educational program for the child in order for them to achieve academic growth.</p> <p>Goals set to support the child to be able to access special education services, Related services SUPPORT systems.</p>	<p>CONSIDER PRESENT LEVELS</p> <p>PRESENT LEVELS OF PERFORMANCE</p> <ul style="list-style-type: none"> Eligibility information Information regarding team/program/services Summary of current work: <ul style="list-style-type: none"> Reading and math assessments Current grades Observed skills/utilization of supports Behavioral referrals Records of work habits. 																					
12/1/2017	<p>Emotional Disturbance</p> <p>Emotional Disturbance</p> <ul style="list-style-type: none"> Unable to comply with requests; needy; difficulty asking for help Misses school due to emotional or psychosomatic issues Uneven achievement due to impaired anxiety, depression, or emotions Poorly developed social skills; immature; difficulty with social cues <p>Socially Maladjusted</p> <ul style="list-style-type: none"> Unwilling to comply with requests; truancy; refuses help Misses school due to choice issues Achievement influenced by truancy, negative attitude toward school, avoidance Well-attuned to social skills; may associate with 	<p>High Incidence Disability Factors</p> <p>Limitations to the 'test-score discrepancy model':</p> <ul style="list-style-type: none"> Requires chronic school failure BEFORE remedial/special education supports can be given Fails to consider that outside factors such as gaps in instruction that may contribute to a child's learning delay. A severe discrepancy provides no useful information about why the student is doing poorly academically. Often different formulas are used by States and districts to diagnose LD, resulting in a lack of uniformity in classification. 	<p>High Incidence Disability Factors</p>  <p>The tree of specific learning disabilities</p> <ul style="list-style-type: none"> Reading Writing Oral Expression Mathematics Listening Comprehension Spelling <p>Specific learning disabilities (SLD) is a term used to describe a range of learning difficulties which can affect basic skills - reading, writing, processing of information and oral/written skills.</p>	<p>REQUESTS FOR EVALUATIONS</p> <p>INSIGHT PA Special Ed Evaluation Request Form</p> <p>Please complete under the student's name ID:</p> <p>What is the student's name?</p> <p>What is the student's birthday?</p> <p>What grade is the student currently placed in?</p> <p>What grade is the student requesting to be placed in?</p> <p>What is the reason for the request to request evaluation/evaluation not provided?</p> <p>What is the parent/guardian's name?</p> <p>What is the parent/guardian's phone number?</p> <p>What is the parent/guardian's email address?</p> <p>What is the parent/guardian's signature?</p> <p>FAMILY-INITIATED REFERRAL</p> <p>Live Survey Link</p>																				
1/10/2018	<p>POWER SCHOOL LOGINS</p> <p>Landing Page</p> 	<p>STAR360 Custom: Training</p> 	<p>Caseload Lists & Metrics Review</p> 																					
2/23/2018	<p>IEPs - Newly identified</p> <ul style="list-style-type: none"> Upon completion sent to SE teacher from Rachel Wise SE teacher uploads to PowerSchool as an attachment IEP generated from ER (Out of state or general ed) High priority NOREPs – Encourage printing/scanning back For initial SE determination, SD should not begin until signed NOREP received 	<p>Post-IEP collaboration & communication</p> <p>Regular Team Communication Step Needs:</p> <p>Copy general ed teachers on email to Parents/IG with finalized IEP & meeting docs attached</p>  <p>Reminder: Set the IEP document Status to Final in PowerSchool to remove the watermark & update teacher BIRCEI sending to parent/IG and Docs to File</p>	<p>ESY determination – PDE outline & Caseload</p>  <ul style="list-style-type: none"> If ESY was previously recommended, ok to maintain on new IEP if insufficient time/participation to rule out continued need. New recommendations for ESY must only be made with the state-determined decision process Resource: ESY Teachers' Desk Reference added to SharePoint (Special Ed Resources & Guides folder) FYI - ESY indicator captured under "Services" section of IEP menu in PowerSchool To Be Determined - Specific ESY dates & framework for SMP 																					
2/28/2018	<p>Highlighting "Behavioral" Disabilities – Solely for the purposes of this topic</p> 	<p>Current "Behavioral" Disabilities</p> <p>Percentages of Total</p> <table border="1"> <thead> <tr> <th></th> <th>TOTAL STUDENTS</th> <th>ED</th> <th>OHI</th> <th>Autism</th> </tr> </thead> <tbody> <tr> <td>K-5 Total</td> <td>30%</td> <td>11%</td> <td>23%</td> <td>11%</td> </tr> <tr> <td>MS Total</td> <td>43%</td> <td>10 + 4</td> <td>16 + 4</td> <td>6 + 1</td> </tr> <tr> <td>HS Total</td> <td>26%</td> <td>5 + 1</td> <td>7 + 2</td> <td>0</td> </tr> </tbody> </table>		TOTAL STUDENTS	ED	OHI	Autism	K-5 Total	30%	11%	23%	11%	MS Total	43%	10 + 4	16 + 4	6 + 1	HS Total	26%	5 + 1	7 + 2	0	<p>504 Vs. IDEA</p> <p>Definitions of Disability: Section 504 and the IDEA include different definitions of "disabilities" or "disabling conditions."</p> <p>IDEA includes 13 categories of disabilities and lists the specific eligibility criteria for each category.</p> <p>Additionally, in order for a student to qualify under IDEA, the disabling condition must result in a need for special education and related services.</p>	<p>Evaluation Process</p> 
	TOTAL STUDENTS	ED	OHI	Autism																				
K-5 Total	30%	11%	23%	11%																				
MS Total	43%	10 + 4	16 + 4	6 + 1																				
HS Total	26%	5 + 1	7 + 2	0																				

																																										
3/15/2018	<h3>Annual IEPs (any type – post 2/26)</h3> <ul style="list-style-type: none"> All generated in PowerSchool format Import for all meetings after 2/26 	<h3>Types of Supports vs. Placement</h3> <p>3. Type of special education supports</p> <ul style="list-style-type: none"> <input type="checkbox"/> Academic Support <input type="checkbox"/> Direct Therapeutic Support <input type="checkbox"/> Indirect Therapeutic Support <input type="checkbox"/> Instructional Support <input type="checkbox"/> Learning Support <input type="checkbox"/> Life Skills Support <input type="checkbox"/> Sensory/Behavioral Support <input type="checkbox"/> Physical Support <input type="checkbox"/> Speech and Language Support 	<h3>General Ed Teacher Consult/Collabo</h3> <ul style="list-style-type: none"> Accommodations/Modifications IEP connection needs IEP Snapshots – ISPA SP site 																																							
5/4/2018	<h3>CASELOADS & WHO'S WHERE?</h3> <table border="1"> <thead> <tr> <th>Caseload</th> <th>Team Member</th> </tr> </thead> <tbody> <tr> <td>K-2</td> <td>Kim Kohler (Lien Russell)</td> </tr> <tr> <td>3-5</td> <td>Nancy Oshoff</td> </tr> <tr> <td>6-7</td> <td>Christan Garrison</td> </tr> <tr> <td>8</td> <td>Nancy Oshoff (Kim Kohler)</td> </tr> <tr> <td>9</td> <td>Jamie Gittinger</td> </tr> <tr> <td>10</td> <td>Kathia Moyer</td> </tr> <tr> <td>Life Skills</td> <td>Anelesse Simon</td> </tr> <tr> <td>Special Populations</td> <td>Kathia Moyer (Projected)</td> </tr> </tbody> </table>	Caseload	Team Member	K-2	Kim Kohler (Lien Russell)	3-5	Nancy Oshoff	6-7	Christan Garrison	8	Nancy Oshoff (Kim Kohler)	9	Jamie Gittinger	10	Kathia Moyer	Life Skills	Anelesse Simon	Special Populations	Kathia Moyer (Projected)	<h3>STUDENT RECORDS & NEW SERVICE NEEDS</h3> <ul style="list-style-type: none"> Larger team meeting scheduled with Operations & Registrar Transitioning ROR process ESY review Printing compliance dates approaching 17-18 Next report date – Sep/Oct 2018 for annual review/RR data collection IEP drafts opened in PE (new enrollments) Up ahead – Regular Special Ed data report at EPA Board Meetings 	<h3>I-ON-I MEETINGS RE: SE COMPLIANCE (VOTE)</h3> <ul style="list-style-type: none"> Framework – IEP spot checks, QA guidance, specific student needs, process/updates Frequency Preference (local) Day/Time Slots (initial) <table border="1"> <thead> <tr> <th></th> <th>Monday</th> <th>Wednesday</th> <th>Friday</th> </tr> </thead> <tbody> <tr> <td>10:00</td> <td>11:00</td> <td>1:00</td> <td></td> </tr> <tr> <td>11:00</td> <td>11:30</td> <td>1:00</td> <td></td> </tr> <tr> <td>12:00</td> <td>12:00</td> <td>2:00</td> <td></td> </tr> <tr> <td>1:00</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Monday	Wednesday	Friday	10:00	11:00	1:00		11:00	11:30	1:00		12:00	12:00	2:00		1:00				<h3>INDIVIDUAL RESOURCE ACCESS NEEDS</h3> <ul style="list-style-type: none"> INIGHT FVETEBANS... You're free to jump into your next work activity of the day! NEW FOLKS... Please stay in the room so we can go through systems and resources. <p>New logins & access barriers?</p> 
Caseload	Team Member																																									
K-2	Kim Kohler (Lien Russell)																																									
3-5	Nancy Oshoff																																									
6-7	Christan Garrison																																									
8	Nancy Oshoff (Kim Kohler)																																									
9	Jamie Gittinger																																									
10	Kathia Moyer																																									
Life Skills	Anelesse Simon																																									
Special Populations	Kathia Moyer (Projected)																																									
	Monday	Wednesday	Friday																																							
10:00	11:00	1:00																																								
11:00	11:30	1:00																																								
12:00	12:00	2:00																																								
1:00																																										
5/11/2018	<h3>17-18 Enrollment Pulse Check</h3> <table border="1"> <thead> <tr> <th>Strat</th> <th>Current Count</th> <th>Today's Update</th> </tr> </thead> <tbody> <tr> <td>Interim</td> <td>89</td> <td>0</td> </tr> <tr> <td>Mobile</td> <td>89</td> <td>0</td> </tr> <tr> <td>High</td> <td>44</td> <td>2</td> </tr> </tbody> </table> <ul style="list-style-type: none"> Source – Total/View Enrollment Lighter Monday "New Starts" Intent to re-register 	Strat	Current Count	Today's Update	Interim	89	0	Mobile	89	0	High	44	2	<h3>"Special Care" for Newly Identified</h3> <ul style="list-style-type: none"> Evaluation Report (ER) reviewed with parent PRCOR TO initial IEP meeting – if not, should be reviewed or meeting "SCHOOLING AND PROCEED" – For "initial provisions," we'd try from 3 to 30 attempts if needed Parent/IG CAN give consent to proceed with meeting if they have reviewed everything and agree with findings Can be notified by parent on invite 	<h3>Related Services & "Non-compliant" Status</h3> <p>SITUATION: You are receiving emails from Showa, showing that a therapist is observing a pattern of missed therapy sessions</p> 	<h3>Related Services & "Non-compliant" Status</h3> <ul style="list-style-type: none"> IMPLICATION: This is documented as a "known barrier" to the implementation of a service. IFA is required to implement, per the IEP Parent contact: – Connect to find out what may be the issue (scheduling/technology/format) and ultimately see if they confirm with progress to coordinate for scheduled therapy sessions. Follow-up with Showa No Parent contact: – Email & VVA still no response... Send invite to IEP revision: "Hold" revision when YOU can (if still no response) 																										
Strat	Current Count	Today's Update																																								
Interim	89	0																																								
Mobile	89	0																																								
High	44	2																																								
6/11/2018	<h3>Summary of Summer</h3> <ul style="list-style-type: none"> Transfer IEP Reviews (Adopt or Hold) Student support groupings New IEP Development (Reviewing, evaluation) In-office file support (WIS/New/Updates) Data entry Document migration Parent welcome call & script 	<h3>End of Year Special Ed PD</h3> <p>Enhance our communications & processes...</p> <ul style="list-style-type: none"> New student enrollment Changes in service Low/No engagement Therapist involvement Assistive technology resources Progress monitoring IEP coordination & expertise 2018 framework & schedule 	<h3>18-19 Caseload Arrangements</h3> <ul style="list-style-type: none"> Type of Support (Academic vs. Functional) Level of Support (Amount outside Gen Ed – IRE) Kindergarten & HS Transition Supports Life Skills Special populations & complex profiles 																																							
6/19/2018	<h3>REFLECTIONS & VISIONS</h3> <p>FOR YOU FOR THE TEAM FOR YOUR STUDENTS</p> 	<h3>18-19 ENROLLMENT BATON RELAY</h3> <p>Steps that... worked, helped, improved, made sense</p>  <p>Steps that... confused, delayed, seemed silly</p>	<h3>The Special Education Enrollment Process</h3> 																																							
8/27/2018	<h3>TOSSING OUT SOME SPECIAL ED MISNOMERS</h3> <ul style="list-style-type: none"> AVOID THE ADJECTIVE... SPECIAL ED DOESN'T DESCRIBE THE STUDENT PEOPLE FIRST – STUDENTS WITH... DISABILITIES OR STUDENTS RECEIVING SPECIAL ED 	<h3>MORE SPECIALTY AREAS OF FOCUS!</h3> <ul style="list-style-type: none"> LIFE SKILLS – ESIMS CASELOAD & HS CASELOAD BEHAVIORALISM (INTENSIVE NEEDS) STAFF SCHOOL PSYCHOLOGIST – AND 2 SUPPORT PSYCHS POST-SECONDARY TRANSITION PRE-REFERRAL INTERVENTIONS (ACADEMIC & BEHAVIORAL) 	<h3>CMGI – SPECIAL ED AUDIT</h3> <ul style="list-style-type: none"> BUREAU OF SPECIAL EDUCATION (BSE) AVG EVERY 5-6 YEARS SURVEYS FOR SE TEACHERS, GE TEACHERS, FAMILIES & STUDENTS (TRANSITION) INSTRUCTIONAL NEEDS & COMPLIANCE 																																							

Insight Pennsylvania Cyber Charter School

Special Education Parent Training Needs Assessment Plan

During the first two years of Insight Pennsylvania Cyber Charter School's operation (2017-2018 and 2018-2019), the school did not provide parent trainings specific to special education. The Bureau of Special Education (BSE) completed cyclic monitoring for continuous improvement of Insight Pennsylvania Cyber Charter School in the spring of 2018 and provided a report of their findings which included the need for parent trainings. In response to the findings from the BSE Compliance Monitoring Review for ISPA, the school has developed the following plan to ensure that parents of students with special education are able to 1) inform the school of their training needs, and 2) have regular access to resources and trainings related to special education.

The following message will be communicated to parents of students with special education prior to the release of the annual ISPA Special Education Parent Training Needs Assessment. The messaging below along with a link to the electronic survey will be emailed to parents.

Dear Insight Pennsylvania Cyber Charter School Parents and Legal Guardians,

You are receiving this email because you have a student enrolled at Insight Pennsylvania Cyber Charter School who receives special education services. The Pennsylvania Department of Education Bureau of Special Education requires all public schools to provide parents with opportunities for training and information sharing to address the special knowledge, skills, and abilities needed to serve the unique needs of children with disabilities. The following link will take you to the Insight Pennsylvania Cyber Charter School Special Education Parent Training Needs Assessment. This online survey will provide the school with valuable information to determine what topics parents want more information on, and areas where parents would like training. There will also be an area available for parents to provide additional comments and feedback to the school. If you have any questions or concerns regarding the survey, please contact Mrs. Jen Jennings, Director of Special Education Compliance, at jejennigs@k12.com.

Thank you for taking the time to complete this survey and helping us provide the best services possible to our students.

The message to parents along with the survey link will be sent to parents during the last week of September and then to the parents of newly enrolled students with special education when a new cohort starts.

Parent trainings may be in the form of live online sessions, recordings, newsletters with links to resources, or in person training events throughout the state.

Below is a timeline for implementation of special education parent trainings.

Monday, September 23, 2019	Initial parent email with survey link will be sent to parents of enrolled students with special education.
Friday, September 27, 2019	Initial survey window will close, and responses will be reviewed by school's Director of Special Education.

Friday, October 4, 2019	Based on survey results, monthly training topics will be determined.
Friday, October 11 2019	First special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, October 15, 2019	First special education parent training will be released via email notice for parents to access.
Friday, November 8, 2019	Second special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, November 12, 2019	Second special education parent training will be released via email notice for parents to access.
Friday, January 10, 2020	Third special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, January 14, 2020	Third special education parent training will be released via email notice for parents to access.
Friday, February 7, 2020	Fourth special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, February 11, 2020	Fourth special education parent training will be released via email notice for parents to access.
Friday, March 13, 2020	Fifth special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, March 17, 2020	Fifth special education parent training will be released via email notice for parents to access.
Friday, April 10, 2020	Sixth special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, April 14, 2020	Sixth special education parent training will be released via email notice for parents to access.
Friday, May 8, 2020	Seventh (final) special education parent training will be completed and available for review by school's Executive Director prior to being released to parents.
Tuesday, May 12, 2020	Seventh (final) special education parent training will be released via email notice for parents to access.

Insight Pennsylvania Cyber Charter School

Special Education Parent Training Needs Assessment

This brief **Needs Assessment** asks about what would be helpful to you. We welcome your comments. Your responses will be used to assist us with planning parent training activities and resources.

Name (Optional): _____ **Date:** _____

Student's Name (Optional): _____ **Grade:** _____

What Would Be Helpful to Me....

I would like more information and/or training on the following topics (select all that apply):

- Understanding my student's disability
- Understanding the special education evaluation process
- What is an IEP and how does it help my student
- Related Services: Speech Therapy, School Social Work, Occupational Therapy, and more
- Helping my student self-advocate
- Progress reports and how I know if my student is making progress
- Accommodations and state testing
- Accommodations in the classroom
- Course of study and ensuring my student is taking the right classes
- Now that my student is 14 or older, understanding transition plans
- My student is turning 17, what does age of majority mean for me and my student
- Support for my student after high school
- Dealing with challenging behaviors
- Supporting my student with executive functioning skills
- Communication strategies with my student and teachers
- Community resources for students with special needs
- Conflict resolution strategies
- Homework strategies
- Test-taking strategies
- Communication with other families
- Other – Please identify

I prefer to access information in the following ways (select all that apply):

- Online recordings that I can access at any time
- PowerPoint Presentations that I can read through as needed
- Written Workbooks, Materials
- List of websites, book titles, and other resources that I can refer to as needed
- Live online workshops where I can chat or talk to others by phone or computer audio
- In person on the weekend (Saturday or Sunday)
- In person during the evening (after 5pm)
- In person during the day (8am – 5pm)
- Other – Please Identify

Please share any comments or questions regarding how our school can best support families of students with special education.