Summary Plan Description

For the

United Cerebral Palsy of Greater Cleveland, Inc. Employee Benefit Plan

As Amended and Restated
Effective as of January 1, 2013

This document together with the Certificates of Coverage or the Component Benefit Plans and other documents identified in this document constitutes the Summary Plan Description.

IN ADDITION, IT IS IMPORTANT TO NOTE THAT ATTACHED AS A SEPARATE DOCUMENT IDENTIFIED AS APPENDIX B IS A CHIPRA NOTICE, WHICH HIGHLIGHTS IMPORTANT RIGHTS THAT YOU AND YOUR FAMILY MAY HAVE REGARDING HEALTH CARE BENEFITS.

UNITED CEREBRAL PALSY OF GREATER CLEVELAND, INC. EMPLOYEE BENEFIT PLAN
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Introduction

United Cerebral Palsy Association of Greater Cleveland, Inc. (the "Employer") hereby amends and restates in its entirety the United Cerebral Palsy of Greater Cleveland, Inc. Employee Benefit Plan (the "Plan"), originally effective January 1, 1993. The Plan's purpose is to consolidate in one plan document certain provisions of welfare benefit plans (the "Component Benefit Plans") sponsored by United Cerebral Palsy Association of Greater Cleveland, Inc. and its affiliated employers, if any, and to provide uniform administration of these welfare benefits. The Component Benefit Plans are listed in **Appendix A** to this Summary Plan Description. This Summary Plan Description ("SPD") is effective January 1, 2013. Presently, there are no controlled group entities of the Employer that have employees participating in the Plan. Participating controlled group entities may be added or changed from time to time.

The insurance contracts, summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the adoption of the Plan and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts, if any, or similar arrangements.) The terms of each Component Benefit Plan are incorporated into this Summary Plan Description by reference and will continue to act as the primary source of information for each Component Benefit Plan. Where a conflict of language exists between the Component Benefit Plan and the Plan or its SPD, the Component Benefit Plan will control to the extent such Component Benefit Plan is not inconsistent with Federal law and regulations. Further, regardless of a Component Benefit Plan's identification of a Plan Year or Plan Number, the provisions of this SPD will control as to such matters.

Note: This material summarizes the legal document that governs the Plan. Every effort has been made to accurately describe the Plan in this SPD. However, if there should be a discrepancy between this SPD and the Plan document -- or if the Plan is required to operate in a different manner to comply with Federal laws and regulations -- the Plan document or the appropriate Federal laws and regulations will control.

If you have not received a Certificate of Coverage (which also may be known as a certificate of insurance or evidence of coverage) or other document that summarizes in detail a Component Benefit Plan, you may request the Certificate of Coverage or other document which will be made available by the Plan Administrator (identified under the heading "Plan Administrator") to you or your beneficiaries without cost.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address or email and the addresses of any family members who are covered by the Plan.

General Information Pertaining to the Plan

Plan Name, Sponsor and Employer EIN

The name of the Plan is United Cerebral Palsy of Greater Cleveland, Inc. Employee Benefit Plan. United Cerebral Palsy Association of Greater Cleveland, Inc. is the Plan Sponsor. The Employer's address is 10011 Euclid Avenue, Cleveland, OH,

44106-4701. The Employer's telephone number is 216-791-8363. You may wish to ask for a representative in the Human Resources department. The Employer's Federal employer identification number (EIN) is 34-0753561.

Plan Year

For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on January 1 and ending December 31. For this purpose, the Plan Year identified here overrides any Plan Year reference in any other documents, if inconsistent.

Plan Number

Each ERISA plan maintained by United Cerebral Palsy Association of Greater Cleveland, Inc. is issued a Plan Number for reporting purposes. The number of this Plan is 501. For this purpose, the Plan Number identified here overrides any Plan Number reference in any other documents, if inconsistent.

Type of Welfare Benefit Plan(s)

The Plan may provide various welfare benefits under the Component Benefit Plan(s) listed in **Appendix A** to this Summary Plan Description.

Funding

Benefits under the Plan are funded by one or more of the following methods selected by United Cerebral Palsy Association of Greater Cleveland, Inc. for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Employer) or through a trust, or a combination of insured benefits, self-funded benefits and trust benefits. For specifics on the funding status of Component Benefit Plans, see **Appendix A.** Funding for the Plan will consist of the sum of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified in **Appendix A.**

United Cerebral Palsy Association of Greater Cleveland, Inc. has the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as United Cerebral Palsy Association of Greater Cleveland, Inc. deems advisable. In addition, United Cerebral Palsy Association of Greater Cleveland, Inc. has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit is funded by the purchase of insurance, the benefit will be payable solely by the insurance company. To the extent funds are transferred to or accumulated in a trust to provide any benefit, that benefit will be payable from the assets of such trust.

Plan Administrator

The Plan Administrator is United Cerebral Palsy Association of Greater Cleveland, Inc., 10011 Euclid Avenue, Cleveland, OH, 44106-4701, telephone number 216-791-8363, which, with respect to insured benefits offered through the Plan, shares the responsibility for administering the Component Benefit Plans with the insurance companies providing benefits under the Component Benefit Plans as named fiduciaries. The insurance companies shown in **Appendix A** to this document are responsible for considering, accepting or denying, and paying claims with respect to the insured benefits. The applicable insurance company is responsible for considering any appeals with respect to the insured benefits made pursuant to a Component Benefit Plan's claim procedures and, to the extent applicable, the claim procedures set forth in

this Plan. Any third-party administrator responsible for administering a Component Benefit Plan not funded through insurance is listed in **Appendix A**. Therefore, the Plan Sponsor is the administrator of the Component Benefit Plan, unless otherwise specified in **Appendix A**, which identifies the administrator as the "Sponsor" or the "Insurer" or the "Contract Administrator." A trust administration program, if any, will also be identified in **Appendix A**. In addition, if a party has accepted named fiduciary status in considering, accepting or denying, and paying claims (including any appeals relating to such claims), such party (also referred to as a "Claim Fiduciary") is identified in **Appendix A**.

Agent for Service of Legal Process

The agent for service of legal process is United Cerebral Palsy Association of Greater Cleveland, Inc., 10011 Euclid Avenue, Cleveland, OH, 44106-4701. Service may also be made on the Plan Administrator and on a trustee (if any) serving with respect to a Component Benefit Plan. The name, title and business address of each Plan trustee of any Plan funded through a trust are listed in **Appendix A**.

Named Fiduciary

The Plan Administrator is the primary named fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary. With respect to the determination of the amount of, and entitlement to, insured benefits under any Component Benefit Plan, however, the respective insurance company is also a named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance policy.

Insurance Company Refund

With respect to any insurance company refunds/rebates received by United Cerebral Palsy Association of Greater Cleveland, Inc. that are subject to the Medical Loss Ratio ("MLR") provisions of the Affordable Care Act, such refunds/rebates must be returned to enrollees consistent with the provisions of the Affordable Care Act. The allocation of insurance refunds that are not participant contributions and are not "Plan assets," are to be used, allocated, and/or distributed among one or more of the Employer(s) as the Controlling Employer in its sole discretion determines appropriate. As to any other amounts, fiduciary decisions are required based on the facts and circumstances relating to the refund. Generally, the following rules will apply:

(a) If the Employer pays the entire premium applicable to the Component Benefit Plan, the entire refund amount will be retained by the Employer;

(b) If the participants pay the entire premium applicable to the Component Benefit Plan, the entire refund amount will be used to benefit the participants;

(c) If the Employer and participants shared premiums based on a fixed percentage, the rebate is divided based on percentage;

(d) If the Employer paid a fixed amount of premiums and participants paid the rest, the rebate is a Plan asset (and must be used for the benefit of the participants) to extent it does not exceed total participant contributions in the relevant MLR period;

(e) If the participants paid a fixed amount and the Employer paid the rest, the rebate belongs to the Employer to the extent it does not exceed the total

Employer contributions in the relevant MLR period;

(f) Allocation among participants of their portion of any refund need not be prorata and may not include all participants (e.g., former participants may be excluded where based on a cost-benefit analysis (provided however in all cases the allocation must be based on a reasonable, fair and objective method));

(g) Refunds attributable to premiums paid from a trust (or segregated account identifying the Plan as the owner) will constitute Plan assets (except in extraordinary circumstances when the Plan document and/or trust agreement provides otherwise and such provisions are reasonable under the circumstances); and

(h) MEWAs may be subject to State regulations which may require additional restrictions on the Employer's ability to receive refunds.

Despite the above general rules, the following conditions apply with respect to Plan assets:

(a) A Plan Fiduciary in all cases must act prudently, solely in the interest of the Plan participants and beneficiaries, and in accordance with the terms of the Plan to the extent consistent with the provisions of ERISA and is prohibited by ERISA from returning a rebate amount greater than the total amount of premiums and other Plan expenses paid by the Employer; and

(b) The use of any refunds for expenses should be limited to those necessary and reasonable expenses (1) paid to a third-party or (2) for reimbursing in-house expenses, but in such case, only upon the advice of outside counsel.

With respect to refunds to participants of a group health plan (whether or not grandfathered), refunds must be allocated among participants in the same policy.

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

(a) First, refunds will be used within 90 days of receipt by the Plan to reduce future premiums; and

(b) Second, refunds will be used within 90 days of receipt by the Plan to enhance benefits, pay expenses, or make distributions to participants as determined by the fiduciary after considering all of the facts and circumstances.

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

Plan Document

The Plan and those documents incorporated by reference constitute a written employee benefit welfare plan as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Grandfathered Health Plan

One or more of the health Component Benefit Plans covered under the Plan may be identified as a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or "ACA") on **Appendix A**. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was

enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans: for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act: for example, the elimination of lifetime limits on benefits.

Questions regarding protections that may or may not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the Plan Administrator at 216-791-8363. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Coverage for Spouses and Dependents

One or more Component Benefit Plans covered under the Plan may identify spouses, dependents/children and others as eligible non-employee participants on **Appendix A**. The provisions relating to such coverage should be detailed in the Certificates of Coverage or other Component Benefit Plan documents.

Coverage for Domestic Partners

One or more Component Benefit Plans under the Plan may identify domestic partners as eligible non-employee participants on **Appendix A** under certain circumstances. The provisions relating to such coverage should be detailed in the Certificates of Coverage or other Component Benefit Plan documents. A Participant should inquire at the time of enrollment elections as to information necessary to apply for such coverage, including any affidavit and/or other documentation required by the Employer. Contact the Plan Administrator if you have questions.

No Guarantee of Non-Taxability

The Plan provides benefits intended to be non-taxable; however, the Plan Administrator or any fiduciary or party associated with the Plan will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

No Guarantee of Employment

The offering of the Component Benefit Plans under the Plan is not a commitment or guarantee of employment by any Employer and does not affect the Employer's rights to discharge any employee.

Eligibility, Participation and Benefits

Eligibility and Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of each Component Benefit Plan. See a summary of more information regarding eligibility and participation in **Appendix A**.

Insurance carriers sometimes impose an "actively at work" requirement for certain types of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. This requirement would be reflected in your Certificate of Coverage. This may also be the case in which you are rehired as an employee.

Contributions

The cost of the benefits provided through the Component Benefit Plans may be

funded in part by Employer contributions and in part by your contributions. In some instances, a Component Benefit Plan may require only you or United Cerebral Palsy Association of Greater Cleveland, Inc. to contribute. If specified in **Appendix A,** the cost of benefits provided through a Component Benefit Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. The sources of Plan contributions are listed in **Appendix A**. United Cerebral Palsy Association of Greater Cleveland, Inc. will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. United Cerebral Palsy Association of Greater Cleveland, Inc. will make its contributions in an amount that in the Employer's sole discretion is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. United Cerebral Palsy Association of Greater Cleveland, Inc. will pay its contribution and your contributions to an insurance company or, with respect to benefits that are self-funded, will use these contributions to pay benefits to a trust, if any, or if none, directly to or on behalf of you or your eligible family members. Your contributions will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit. Where relevant to a Component Benefit Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Component Benefit Plan is adjusted during the Plan Year, you will be notified of such adjustment unless the Component Benefit Plan provides otherwise.

The Plan Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual, organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Plan consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions with respect to each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to payment by the participant of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan. Any health care flexible spending account under a cafeteria plan will be subject to this Plan and the requirements of ERISA. Nonetheless, such premium or premium equivalent (i.e., the cost of coverage) reduction portion of a cafeteria plan (and any dependent care assistance plan offered under the cafeteria plan) will not be subject to the requirements of ERISA, even though the cafeteria plan (and any dependent care assistance plan) may be considered part of the Plan.

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), Plan participants will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a benefit document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what circumstances coverage is provided for emergency and out-of-network services.

Loss of Benefits

Your benefits (and the benefits of your eligible dependents) generally will cease when your participation in the Plan terminates. Benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents of the Component Benefit Plans provide additional information.

Benefit Elections

Electing Your Benefits for the Plan Year Under a Component Benefit Plan

Some of the Component Benefit Plans require that you make an annual election to enroll for coverage for the next plan year prior to the beginning of that year. The plan year for each Component Benefit Plan should be set forth in such plan and may be different than the Plan Year for this Plan. Thus, the discussion below regarding plan year refers to the relevant Component Benefit Plan's plan year.

If you first become eligible to participate in a Component Benefit Plan during a plan year in progress, your initial elections pertain to the remaining part of that plan year. Then, before each new plan year begins, you will have an opportunity to change or cancel your elections during the annual election period. The annual election period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Component Benefit Plan. You may also elect not to participate in a Component Benefit Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form in a format approved by the Employer (whether in paper or electronic format) before the end of the annual election period. When you make your elections, you also authorize the necessary salary reductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a plan year, you will be given an opportunity to elect and enroll in the benefits for which you are newly eligible.

Annual Election Period

Before the beginning of each plan year, United Cerebral Palsy Association of Greater Cleveland, Inc. often will hold an annual election period. In such case, United Cerebral Palsy Association of Greater Cleveland, Inc. will notify you when the dates for the annual election period will occur each year. During this time, you may make new elections for the upcoming plan year.

Changing Your Elections during a Plan Year

Where a Component Benefit Plan is funded through a cafeteria plan, once you have made your elections for a plan year, it pertains to the entire plan year as it applies to that Component Benefit Plan and cannot be changed or cancelled during that time except in certain limited situations which are described in the cafeteria plan. Other election restrictions may apply to Component Benefit Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a third-party administrator must be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement. These procedures will be followed unless inconsistent with the requirements of ERISA as specified in more detail below. The name (and in the case of group health plan claims, the address) of the individual insurance company providing benefits and reviewing claims relating to its insurance policy is set forth in **Appendix A**. Further, the name and address of the third-party administrator (if any) that reviews claims made under a Component Benefit Plan may be set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

Personal Representative

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

Your personal representative will be required to produce evidence of his or her authority to act on your behalf and the Plan may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information ("PHI") or allowed to take any action for you. (A mere assignment of your benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan.) This authority may be proved by one of the following:

(a) A power of attorney for health care purposes, notarized by a notary public;

(b) A court order of appointment of the person as the conservator or guardian of the individual; or

(c) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General Claims Procedure

The Plan's claims procedures are described below. (These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") or to any dependent care assistance plan offered thereunder.)

The following procedures will be followed for denied claims under a Component Benefit Plan that is not a group health plan or disability plan. For group health claims and disability claims, see headings "Special Rules for Group Health Plan Claims" and "Special Rules for Disability Claims."

(a) If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. The notification will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

(b) Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator. Documents or records in support of your appeal should accompany any such request. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator (or the applicable insurance company that has accepted its fiduciary responsibility to make claim determinations with respect to the applicable insured plan) has the exclusive and discretionary right to interpret the appropriate plan provisions. Decisions of the Plan Administrator (or insurance company or other party accepting claims responsibility) are conclusive and binding. *To the extent not inconsistent with the provisions of the applicable Component Benefit Plan, a claimant will be barred from bringing the claim after one year from the date of exhausting the Plan's claims procedures relating to the denial of the claim. In the case of a group health plan claim discussed below, this includes not only exhausting the Plan's internal claims procedure but also exhausting the Plan's external claims procedure, where applicable.*

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are three categories of claims under a Component Benefit Plan that is a group health plan (e.g., medical, dental, vision and health care flexible spending account benefits) and each one has a specific timetable for approval, payment, request for additional information, or denial of the claim. The three categories of claims are:

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

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

Post-Service Claim is a request for payment for covered services you have already received.

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

Note that fully-insured plan claims (if any) may be subject to an even more accelerated response time by the insurance company handling the claim. See Certificates of Coverage for details.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied.

The notice will contain the following information:

(1) the specific reason or reasons for the adverse determination;

(2) reference to the specific Plan provisions on which the determination was made;

(3) a description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action under ERISA Section 502 if your claim is denied on review;

(5) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;

(6) if an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request; and

(7) if the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge (upon request of such person or persons) who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal your claim. A failure to timely file an appeal request will constitute a waiver of your right to request a review of the denial of your claim. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review should contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

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

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

Pre-Service Claim – 15 days.

Post-Service Claim – 30 days.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

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

* The Employer should decide the appeal of "concurrent care claims" within the time frame set forth above depending on whether such claim is also an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment.

Special Internal Appeals Review Procedures Under ACA

Under the Affordable Care Act, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage (e.g., certain separate dental and vision plans and most FSAs) of the Plan based upon, generally whether the Plan is (1) fully-insured or (2) self-funded *with respect to any "Adverse Benefit Determination" (e.g., decision involving a determination regarding medical judgment or a recession of coverage)*.

(a) A rescission is permissible only upon a finding of fraud or intentional misrepresentation of a material fact;

(b) You must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. It must also provide you with any new or additional rational for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to the new evidence or rationale;

(c) Decisions regarding hiring, compensation, termination, promotion, etc. by a claims adjudicator or medical expert may not be based on the likelihood that such person will support the denial of benefits due to that influence (this is to avoid conflicts of interest);

(d) Notices to claimants by the Plan or Claim Fiduciary must also include additional content as follows:

(1) Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient

to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon your request, the diagnosis code and treatment code and their corresponding meanings will be provided.

(2) Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

(3) A description of available internal appeals and external review processes, including information about how to initiate an appeal.

(4) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

(5) For Plan Years beginning on or after January 1, 2012, notices of any Adverse Benefit Determination must be in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any claimant in the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in such other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Plan or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

(e) Generally, the Plan's or Claim Fiduciary's failure to adhere to the requirements of the ACA will allow you to deem the internal claims and appeals process "not in compliance" under the Affordable Care Act, therefore declaring your claim procedure "exhausted." At this point, you may proceed to pursue any external review process or remedies available under ERISA or under State law, if applicable.

You may appeal this determination by requesting external review described in more detail, below.

Special State External Appeals Review Process Under ACA

You should be aware that the Department of Labor ("DOL") has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination relating to *insured health benefits* (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules).

(a) A State may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections;

(b) A State may operate an external review process under "similar standards to those outlined in the July 2010" interim final rule (These "similar standards" apply until January 1, 2014); or

(c) Where the State meets the "strict standards" or the "similar standards," your health plan is subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to you by the insurance company or the Plan.

Meets Strict		Meets Similar	HHS Administered Process/Independent Review Organization Process	
States		States	States	Territories
Arkansas	New Jersey	Arizona	Alabama*	American Samoa*
California	New York	Delaware	Alaska	Guam*
Colorado	Oklahoma	District of Columbia	Florida	Northern Mariana Islands*
Connecticut	Ohio	Indiana	Georgia	Puerto Rico
Hawaii	Oregon	Kansas	Louisiana	U.S. Virgin Islands*
Idaho	Rhode Island	Massachusetts	Mississippi*	
Illinois	South Carolina	Michigan	Missouri	
Iowa	South Dakota	Minnesota	Montana	
Kentucky	Utah	New Mexico	Nebraska*	
Maine	Vermont	North Carolina	North Dakota	
Maryland	Virginia	Tennessee	Pennsylvania	
Nevada	Washington	Wyoming	Texas	
New Hampshire	Wisconsin		West Virginia	

* As of June 22, 2011, these States participate in the Federal Health and Human Services ("HHS")-administered process. States having neither met the "strict standards" nor the "similar standards" will be subject to either (1) the HHS-administered process or (2) the DOL's Federal external appeals review process (described in more detail below). A State may change its external review process in the future. You must, at a minimum, be notified at the time the claim is filed of the process to be followed. For more information, visit http://cciio.hhs.gov/resources/files/external_appeals.html.

Special Federal External Appeals Review Process Under ACA

Generally, Plans that are either *self-funded* (are not provided through insured health benefits) or *have not elected or are not eligible to qualify for the State review external appeals process* for any Adverse Benefit Determination are subject to Federal review process described below.

(a) You will have four months to request an external review of any final internal Adverse Benefit Determination.

(b) The Plan or Claim Fiduciary has five business days to complete a preliminary review to determine if the claim is eligible for external review (determining whether you were covered (eligible) at the time the

service was provided, whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully.

(c) Within one business day after the preliminary review, the Plan or Claim Fiduciary will notify you in writing of its decision. If the claim is complete but not eligible for external review, you will be provided with the reason for its ineligibility and as well as contact information for the Employee Benefits Security Administration. If the claim is incomplete, you will be provided with an explanation of what is necessary to complete the claim and the Plan or Claim Fiduciary must give you a reasonable time to complete the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompletion).

(d) If you appeal an appealable final internal adverse benefits determination (or challenges whether or not it is appealable), your claim must be referred to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct external reviews, through an unbiased selection process involving several IROs.

(e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days after the IRO receives the assignment.

(f) If the IRO reverses the decision of the Plan or Claims Administrator, your payments or coverage must begin immediately, even if the Plan or Claims Administrator expects to appeal it to a court of law.

(g) You must also have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request.

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

The Plan intends and is taking steps in good faith to comply with the claims and appeals rules under the Affordable Care Act and the provision herein should be interpreted accordingly.

Special Rules for Disability Claims

A disability claim requires the Plan to determine if you are disabled for purposes of eligibility for disability benefits under a Component Benefit Plans. The Plan will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. You may appeal the

Plan's determination within 180 days following receipt of an adverse determination. The Plan will notify you of its determination on review within 45 days and in accordance with the procedures set forth in paragraph (b) under the heading "General Claims Procedure."

Coverage While on Leave of Absence

Family and Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to employers with 50 or more employees within a 75 mile radius. FMLA also requires you to have worked a certain number of hours and months in order to be eligible. If you have questions regarding FMLA's applicability to you, you should contact the Plan Administrator for more details. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. Such family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee's job.

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

If you are eligible and choose to take FMLA leave, your Employer must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Any changes to the group health plan during the time you are on FMLA leave apply to you. Your Employer must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your employer has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you will be no longer covered, but upon your return to employment, the employer is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical necessity, then you may be required to reimburse your employer for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your employer cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you drop health coverage during your FMLA leave, any days without health

coverage while on leave will not count toward a 63-day break in coverage relating to another health plan. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

Military Service Leave (USERRA Coverage)

Any participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), will continue to participate and be eligible to receive benefits under any Component Benefit Plan that is a group health plan in accordance with USERRA rules and regulations.

If you were covered under a Component Benefit Plan which is a group health plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service begins, if you pay any required contributions toward the cost of your group health plan coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

(a) You fail to make a premium payment (or premium equivalent) within the required time;

(b) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

(c) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "Other Continuation/Conversion Privileges."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA. See the Plan Administrator for details.

Federal Rights of Individuals Under Health Plans

Benefits for Adopted Children

If the group health plan under which you are covered provides benefits for dependent children, United Cerebral Palsy Association of Greater Cleveland, Inc. group health plan will extend benefits to dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Children's Health Insurance Program Reconciliation Act

The Children's Health Insurance Program ("CHIP") was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In the case of group health plans, an amendment to CHIP designated "CHIPRA" allows States to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. It also allows for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage. Each State in which an employee resides will choose whether it will implement this optional subsidy.

Generally, if you are eligible, you may be able to enroll in the employer's group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your State has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details. Attached, as **Appendix B,** is a chart with more contact information.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Generally, where COBRA applies, if you or your eligible family members' group health plan coverage ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You may also have coverage continuation rights under State insurance laws. Information on State insurance law continuations is contained in the Certificate of Coverage (or its equivalent) which is incorporated by reference in **Appendix A**. As an additional benefit, the Employer may extend to same-sex spouses, civil union partners, and qualified same-sex domestic partners the rights which may parallel the Federal laws of COBRA ("COBRA-like rights"). It should be noted that any COBRA-like rights offered by an employer presently do not enjoy the same income tax benefits at the Federal level and may not at the State level. This document does not address Federal, State and local tax treatment in detail, and is not intended to provide tax advice. For information on how applicable tax laws may apply to your personal situation, consult your tax adviser. See applicable Certificate of Coverage (or its equivalent) as well as the Plan Administrator for details.

If you, your spouse, or your dependents lose coverage under the Plan because you experience a life event known as "qualifying event," you and/or your spouse and dependents may be eligible to elect continuation coverage under COBRA for the portions of the Plan that are a "group health plan" (e.g., medical, dental, vision and health care flexible spending account ("health care FSA") benefits).

You, your spouse, or your dependents experience a "qualifying event" under COBRA if your employment terminates (or your hours are reduced making you ineligible for participation) for reasons other than gross misconduct. Additionally, your spouse or your dependents may experience a "qualifying event" due to your divorce, legal separation, death, or entitlement to Medicare. If you (or your spouse or your dependents) experience one of these qualifying events, and as a result lose coverage under the Plan, you (or your

spouse or your dependents) may be eligible for COBRA.

To be eligible for COBRA in the event of a divorce or legal separation, or if your dependents become ineligible under the Plan, you, your spouse, and/or your dependents must notify the Plan Administrator as soon as possible after the qualifying event occurs, and no later than 60 days after the qualifying event occurs. You must provide this notice, in writing to the Plan Administrator. In order to protect your rights, you should keep the Plan Administrator informed of any changes in the address of you, your spouse, and/or your dependents.

The Plan Administrator will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after your participation ends or you receive this form, whichever is later. The Plan will offer COBRA continuation coverage only after the Plan Administrator has been notified that a qualifying event has occurred.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA. You may elect COBRA on behalf of your spouse, and you or your spouse may elect COBRA on behalf of your children.

When the qualifying event is your death, your entitlement to Medicare benefits, your divorce or legal separation, or a dependent's losing eligibility as dependents, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is your termination of employment or reduction of hours of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries (other than you) may last for up to 36 months after the date of Medicare entitlement. In some situations (described below), COBRA may last up to 29 or 36 months. Otherwise, when the qualifying event is your termination of employment or reduction of hours, COBRA generally lasts for only up to a total of 18 months. There are two ways in which the 18 month period of COBRA can be extended:

(a) *Disability Extension.* If you or any of your covered dependents is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18 month period of COBRA. To be eligible for this disability extension, you must notify the Plan Administrator of the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month COBRA period. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator within 30 days after the SSA's determination.

(b) *Second Qualifying Event Extension.* If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your

spouse and dependents can get up to 18 additional months of COBRA coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the occurrence of the second qualifying event. This extension may be available to your spouse and dependents receiving COBRA if you die, become entitled to Medicare benefits, or get divorced or legally separated, or if your dependents stops being eligible under the Plan as a dependents, but only if the event would have caused your spouse or dependents to lose coverage under the Plan had the first qualifying event not occurred.

There are a few cases in which a COBRA participant could lose COBRA coverage early. A COBRA participant is no longer entitled to COBRA if the participant becomes covered under another group health plan, fails to make the required contributions on time, becomes entitled to Medicare benefits (under Part A and/or Part B or both, including if someone has also enrolled in Medicare Advantage), or the Plan Administrator ceases to provide any health plan benefits.

To continue your group health coverage, you and/or your covered dependents may be charged up to 102% of the full cost of coverage (or 150% in the case of an 11-month extension due to disability). You make this payment during the 18, 29 or 36-month period of continuation coverage. The first premium payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include your COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date. Premium payments should be sent to the Plan Administrator's address.

If health care FSA coverage is offered under the Plan, COBRA continuation for such coverage ends on the last day of the calendar year in which the qualifying event occurs. However, COBRA will not be provided under the health care FSA if, as of the date of the qualifying event, you would not receive (during the remainder of the Plan Year) a benefit under the health care FSA that is more than the amount you would pay for COBRA for the remainder of that Plan Year.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act ("GINA") states that health benefit plans may not discriminate on the basis of genetic information with respect to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or "business associate" of the employer. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies genetic information is treated as protected health information ("PHI") under another Federal law called "HIPAA". The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can your Employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

HIPAA Rules

Information you provide for purposes of a health plan sponsored by the Employer may be PHI under Privacy Standards established under the Health Insurance Portability and Accountability Act ("HIPAA"). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also PHI. Your HIPAA privacy rights are described in a notice set forth in **Appendix C**. If you have questions about this law, you should contact the Plan Administrator.

Some group health plans are subject to HIPAA portability rules while others are not. Group health plans that are generally not subject to HIPAA (and therefore are considered "HIPAA-excepted coverage") include for example certain limited dental and vision plans.

In addition, a group health plan that is subject to HIPAA portability must comply with the following:

If a group health plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Within a reasonable time following the receipt of a Certificate of Creditable Coverage or other evidence of Creditable Coverage, a group health plan must make a determination regarding the length, if any, of the Preexisting Condition limitation that will apply to you or your eligible dependent, if applicable, and provide notice of this determination. These rules are explained in some detail in the underlying documents relating to the applicable group health plan. A group health plan has the right to reconsider and modify its initial determination if it is later determined that the claimed Creditable Coverage did not exist. However, where a reconsideration is made and the determination is modified, a notice of the new determination must be provided to you and until the new notice is provided, the health plan, for purposes of approving access to medical services, must act in a manner consistent with the initial determination of Creditable Coverage.

A group health plan must provide for special enrollment opportunities. These rules are explained in some detail in the underlying documents relating to the applicable group health plan. One additional opportunity for special enrollment must occur when you or your eligible dependent incur a claim that would exhaust lifetime benefits under previous coverage. The special enrollment period will continue until 31 days after a claim is denied due to the operation of the lifetime limit on the group health plan benefits.

Where extension of benefits has been made to same-sex spouses, civil union partners, and qualified same-sex domestic partners, the HIPAA privacy rights will apply.

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as de-ductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage,

limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits provided. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

Michelle's Law

Many health plans extend health benefits of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by your Employer for continued coverage under the health plan. Due to a recent law known as Michelle's Law, group health plans must provide extended coverage to dependents of any participant who as full-time students in postsecondary educational institutions would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection under Michelle's Law. Your Employer may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier, the date the coverage would otherwise end under the Component Benefit Plan.

Newborns' and Mothers' Health Protection Act

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

While the Affordable Care Act provision that requires extension of coverage for dependents until age 26 will often make reliance upon Michelle's Law unnecessary, Michelle's Law still will have relevance in certain circumstances such as its applicability to HIPAA-excepted coverage (to which the Affordable Care Act does not apply).

Qualified Medical Child Support Orders

The Employer's group health plans will provide benefits as required by any qualified medical child support order ("QMCSO") in accordance with ERISA. The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (the "Affordable Care Act") of 2010 requires the modification of group health plans in a number of ways. Some of these significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following group health plans *that are neither grandfathered nor HIPAA-excepted coverage*:

(a) If you need to receive emergency services in the emergency department of a hospital, you do not need prior

authorization, and your cost-sharing obligations (including co-payments and co-insurance) will be the same regardless of whether you receive prior approval as would be applied to care received by preferred providers; however, you may be responsible for the allowed amount under your plan and what is billed by a non-network provider, to the extent permitted by the Affordable Care Act;

(b) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special previsions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women;

(c) If your health plan requires or allows you to select a primary care physician ("PCP"), you can designate any participating PCP (who participates in the network and who is accepting new patients) as your PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered dependent child; if the group health plan designates a PCP automatically, until you make this designation, the group health plan or health insurer will designate one for you. Where selection of a PCP is required or allowed, contact the Plan Administrator or issuer at the telephone numbers listed as contacts under **Appendix A** for information on the selection process;

(d) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or issuer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or issuer at the telephone numbers listed as contacts under **Appendix A**; and

(e) Internal appeal and external review claim procedures are revised as provided in the "Claims Procedures" section of this SPD.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *both grandfathered and non-grandfathered health plans that are not HIPAA-excepted coverage*:

(a) The pre-existing condition limitation does not apply to a covered person under age 19;

(b) Any lifetime maximum no longer applies to essential health benefits (to the extent covered under the group health plan) which, include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and

chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential Health Benefits"). If a covered person lost coverage due to a lifetime maximum dollar limit as to Essential Health Benefits prior to the effective date of the Affordable Care Act but is still otherwise eligible for the coverage, that lifetime limit no longer applies and will have a special enrollment right and 30-day enrollment window if previously excluded due to such limitation;

(c) No rescissions in health plan coverage will be allowed except for fraud or an intentional mis-representation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded; and

(d) If your health plan includes coverage for dependents, your child (including step-child, legally adopted child, a child placed for adoption and a child under a QMCSO or National Support Notice) is covered until the child turns age 26 regardless of the child's tax dependent status and will have a special enrollment right and 30-day enrollment window if previously excluded due to an age limitation.

Restrictions on annual dollar limits may be imposed on Essential Health Benefits for both grandfathered and non-grandfathered group health plans that are not HIPAA-excepted (to the extent provided under the group health plan) that are not less than:

(a) $750,000, for plan years beginning on or after September 23, 2010 but before September 23, 2011;

(b) $1,250,000, for plan years beginning on or after September 1, 2011 but before September 23, 2012; and

(c) $2,000,000, for plan years beginning on or after September 23, 2012 but before January 1, 2014. (For future plan years, no annual limits are permitted.)

The above includes certain minimum provisions of the Affordable Care Act. In certain cases, a Component Benefit Plan's Certificate of Coverage may be more generous than the Affordable Care Act requires. Therefore, you should review the Certificate of Coverage for details.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified in **Appendix A.** Call your Plan Administrator for more information.

Wellness Program

Where a wellness program subject to HIPAA is offered under the Plan, a reward may be offered based on certain standards of achievement. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Plan Administrator and we will work with

you to develop another way to qualify for the reward.

Employer's Rights under the Plan

Employer's Right to Change or End the Plan

United Cerebral Palsy Association of Greater Cleveland, Inc. reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time. Any affiliated employer reserves the right to withdraw from and terminate its participation in the Plan, thereby terminating, suspending, amending or modifying the Plan as to its Plan participants. Generally, unless specifically provided otherwise in an underlying document such as a trust agreement relating to the applicable Component Benefit Plan, any amounts remaining in the Plan at termination will be distributed as if they were insurance company refunds/rebates (see heading "Insurance Company Refund").

Employer's Right to Interpret the Plan

United Cerebral Palsy Association of Greater Cleveland, Inc. has the right to appoint the Plan Administrator of the Plan. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan. The Plan Administrator's interpretations and decisions are conclusive and binding on all Plan participants.

Employer's Right of Reimbursement

To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the following provisions will control as to any medical or dental Component Benefit Plan.

If you, your spouse, or your dependent incur medical or dental expenses or receive benefits from the Plan or its carrier as a result of an injury or accident, immediately upon payment of any benefits under the Plan, the Plan will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan.

If you, your spouse, or your dependents receive any reimbursement from any party as a result of an injury, the Plan has the right to recover the amounts the Plan has paid and will pay as a result of that injury, from any amounts you, your spouse, or your dependents received from any party. Similarly, if any person, including any natural person or entity, other than you, your spouse, or your dependents have possession of funds recovered from a third party as to which you, your spouse, or your dependents have a claim, then the Plan will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. You, your spouse, or your dependents agree to assist the Plan in its attempt to recover from that person. In the event that you, your spouse, or any of your dependents is deceased, the Plan has a right to recover funds from the estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with your, your spouse's, or any of your dependents' claims without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

You, and individuals acting on your behalf, including attorneys, will do nothing to prejudice the Plan's subrogation and reimbursement rights and will, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is your duty, and

the duty of individuals acting on your behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when you give notice to any other party, including an attorney, of your intention to pursue or investigate a claim to recover damages on behalf of yourself, your spouse, or your covered dependents.

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

Other Continuation / Conversion Privileges

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the State to which your coverage applies (for example, California, New York, etc.) for certain insured benefits. The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

Also, when you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

ERISA Rights

You are entitled to certain rights and protections under ERISA. ERISA provides that Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including any applicable insurance contracts and collective bargaining agreements, if any 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 any applicable insurance contracts, and collective bargaining agreements, if any 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 (Form 5500), if any is required by ERISA to be prepared. Where the annual financial report must be prepared, the Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

- Continue health care coverage for yourself or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the group health plans for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plans, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining health benefits or exercising your rights under ERISA.

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

- Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any is required to be prepared, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a qualified domestic relations order or a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from

the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your benefits or the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A: Component Benefit Plans

The information below is effective January 1, 2013, unless otherwise indicated below.

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed is the name (and in the case of group health plan claims, the address and telephone number) of the individual insurance company that provides benefits (if any) and review claims relating to its insurance policy. Also below may be a list of the name and address of the third-party administrator (if any) that reviews claims made under a Component Benefit Plan as well as the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below, an eligible Employee with respect to the Plan is any regular common-law employee of United Cerebral Palsy Association of Greater Cleveland, Inc. who is not a leased employee, independent contractor, temporary employee, seasonal employee, casual employee, or former employee, and such regular common-law eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Non-resident aliens are also not eligible. To determine whether you are eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

Group Medical PPO Attachment 1	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Spouses, Dependents/Children
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Medical Mutual of Ohio; 2060 E. 9th Street; Cleveland, OH 44115; 1-800-218-2205
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Group Dental Attachment 2	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Spouses, Dependents/Children
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	Yes
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Guardian; PO Box 2459; Spokane, WA 99210-2459; 1-800-541-7846
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Long-Term Disability Attachment 3	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	No coverage for spouses, dependents, or domestic partners
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Reliance Standard Life Insurance Company; 2001 Market St. Suite 1500; Philadelphia, PA 19103; 1-800-351-7500
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Life Attachment 4	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	No coverage for spouses, dependents, or domestic partners
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Reliance Standard Life Insurance Company; 2001 Market St. Suite 1500; Philadelphia, PA 19103; 1-800-351-7500
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Short-Term Disability Attachment 5	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 20.0 Hours per Week and Earn an Annual Salary of at Least $9,000
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	No coverage for spouses, dependents, or domestic partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Reliance Standard Life Insurance Company; 2001 Market St. Suite 1500; Philadelphia, PA 19103; 1-800-351-7500
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Vision Attachment 6	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is 90 days for non-exempt employees, 30 days for exempt employees
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees	Spouses, Dependents/Children
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	Yes
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Eyemed Vision Care; Fidelity Security Life Insurance Company; 3130 Broadway; Kansas City, MO 64111-2406; 1-800-648-8624
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Appendix B: CHIPRA Notice

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility -

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9948

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website:
http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website:
http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/OIAS/public-assistance/index.html
Phone: 1-800-572-3839

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website:
http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx
Phone: 1-877-255-3092

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website:
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website:
http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml
http://www.hijossaludablesoregon.gov
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website:
http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website:
https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website:
http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website:
http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website:
http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
http://health.wyo.gov/healthcarefin/equalitycare
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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Appendix C: HIPAA Privacy Notice

NOTICE OF PRIVACY PRACTICES
United Cerebral Palsy Association of
Greater Cleveland, Inc. (THE "EMPLOYER")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS MANDATED FOR HEALTH PLANS THAT ARE SUBJECT TO HIPAA. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Employer-sponsored health plans ("the plans"). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy with respect to your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices with respect to health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information About You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be

paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to United Cerebral Palsy Association of Greater Cleveland, Inc. in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed to so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is use only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by United Cerebral Palsy Association of Greater Cleveland, Inc. for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by United Cerebral Palsy Association of Greater Cleveland, Inc..

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services ("HHS"). The plans may disclose your PHI to HHS for the

investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan

eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect and copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. *Note: The plans are not required to agree to your request.*

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about *health* matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits ("EOB") forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Privacy Officer to request a written copy of this notice at any time.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidences of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such

authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Changes to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally, within 180 days of when the act or omission complained of occurred. *Note: The plans will not retaliate against you for filing a complaint.*

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact United Cerebral Palsy Association of Greater Cleveland, Inc., 10011 Euclid Avenue, Cleveland, OH 44106-4701.