CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT

EMPLOYEE BENEFIT PLAN

HDHP PLAN DOCUMENT

AMENDED

Effective: 03/01/2017 and 07/01/2017

Non-Grandfathered Health Plan Notice:

This Chippewa Falls Area Unified School District Employee Benefit Plan believes that this Plan is a "non-grandfathered health plan" under the Affordable Care Act (ACA).

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CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Chippewa Falls Area Unified School District (the "Company or the "Plan Sponsor") as of July 1, 2014 hereby **amends and restates** the Chippewa Falls Area Unified School District Employee Benefit Plan (the "Plan"), which was originally adopted by the Company effective July 1, 1988.

Effective Date

The Plan Document is effective as of the date first set forth above and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settler of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Chippewa Falls Area Unified School District

By: Michelle Golden

Name: Michelle Golden

Date: 7/26/17

Title: Exec. Director of HR

Record of Plan Amendments

Amendment Number	Amendment Date	Subject of Amendment
#1	July 1, 2014	Breast feeding, copays, & termination of coverage
#2	July 1, 2014	Therapeutic devices in Rx area
#2	January 1, 2015	Virtual care, HSA deductibles, language updates
#3	July 1, 2015	Renewal updates
#4	January 1, 2016	Deductible & MOOP, loss of grandfather status
#5	February 1, 2016	Newborn eligibility
#6	July 1, 2016	Renewal updates, split plans
#7	January 1, 2017	Deductible & MOOP
#8	March 1, 2017 and July 1, 2017	Cardinal Healthy Primary Care Clinic and The Joyful Doc Clinic added as in network providers Renewal updates

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees of Chippewa Falls Area Unified School District, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by Chippewa Falls Area Unified School District and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Chippewa Falls Area Unified School District Employee Benefit Plan**
Plan Sponsor:	**Chippewa Falls Area Unified School District 1130 Miles Street Chippewa Falls, WI 54729 Phone: (715) 726-2417**
Plan Administrator: (Named Fiduciary)	**Chippewa Falls Area Unified School District 1130 Miles Street Chippewa Falls, WI 54729 Phone: (715) 726-2417**
Plan Sponsor ID No. (EIN):	**39-6008493**
Source of Funding:	**Self-Funded**
Plan Year:	**July 1 through June 30**
Group Number:	**3126**
Plan Number:	**503**
Plan Type:	**Medical and Prescription Drug**

Claims Administrator:	**Benefit Plan Administrators of Eau Claire, Inc.** **402 Graham Avenue – 4th Floor** **Eau Claire, WI 54701** **Phone: (715) 832-5535** **Phone: (800) 236-7789** **Website: www.bpaco.com**
Participating Employer(s):	**Chippewa Falls Area Unified School District**
Agent for Service of Process:	**Chippewa Falls Area Unified School District** **1130 Miles Street** **Chippewa Falls, WI 54729** **Phone: (715) 726-2417**

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity
Pursuant to the Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008, (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law
This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participant's rights in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be read in such a way so as to conform with any and all applicable law, regulation or court order (if such a court is of competent jurisdiction). Where necessary, the governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations are deemed to be automatically amended to so conform.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT
EMPLOYEE BENEFIT PLAN

HDHP
SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
ANNUAL MAXIMUM BENEFIT	Unlimited	
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Individual Family (Embedded)	 $3,000 $6,000	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR Individual Family (Embedded)	 $3,500 $7,000	 $4,000 $8,000
After the deductible has been satisfied, allowable charges will be paid at 90 percent or 80 percent until the maximum out-of-pocket expense amount is met. Allowable charges from Preferred Providers will be paid at 90 percent. Allowable charges from all other qualified providers will be paid at 80 percent. Once the maximum out-of-pocket expense amount is met, the Plan will then pay 100 percent of all allowable charges.		
The following charges are excluded from the major medical deductible requirement or maximum out-of-pocket expense and are never paid at 100%: • Ineligible Charges • Charges in excess of the Plan maximums/limitations • Charges over the Usual and Customary and Reasonable Fee • Rx Ancillary Charges		
Note: **1. Maximum out-of-pocket includes the major medical deductible.** **2. Deductible and/or maximum out-of-pocket amounts are combined for Preferred Provider and non-Preferred Provider expenses.** **3. Copays apply towards the maximum out-of-pocket expense.** **4. Cardinal Healthy consult fees apply towards the deductible and maximum out-of-pocket expense.**		

Inpatient pre-admission certification and Outpatient pre-certification – This is a **voluntary program** that verifies the need for all Inpatient Hospital admissions and reviews the number of days requested for each admission and verifies the need for Outpatient chemotherapy/radiation therapy and dialysis.. Inpatient preadmission Certification and Outpatient pre-certification should take place prior to a planned admission or listed Outpatient procedure. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section ***"Hospitalization Utilization Review Program"*** **and "Outpatient Pre-Certification"** for details.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Allergy Tests and Injections	90% after Deductible	80% after Deductible
Ambulance Services Includes air transportation to the nearest, most appropriate medical facility.	90% after Deductible	90% after PPO Deductible, Usual and Customary and Reasonable apply
Ambulatory/Outpatient Surgery Care	90% after Deductible	80% after Deductible
Anesthesia Inpatient/Outpatient	90% after Deductible	80% after Deductible
Autism Spectrum Disorder Treatment Calendar Year benefit is limited to the annual Intensive level and Non-Intensive level specified by state law statute 632.895. These amounts change each year based on the Consumer Price Index.	90% after Deductible	80% after Deductible
Birthing Center Care	90% after Deductible	80% after Deductible
Cardinal Healthy Primary Care Clinic Services	$25.00 consult fee	
Consultant (In-Hospital)	90% after Deductible	80% after Deductible
Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care.	90% after Deductible	80% after Deductible
Calendar Year maximum benefit	18 visits	
Contraceptives	100% Deductible waived	80% after Deductible
Dental Services Accidental Injury/Oral Surgical Procedures	90% after Deductible	80% after Deductible

Inpatient pre-admission certification and Outpatient pre-certification – This is a **voluntary program** that verifies the need for all Inpatient Hospital admissions and reviews the number of days requested for each admission and verifies the need for Outpatient chemotherapy/radiation therapy and dialysis.. Inpatient preadmission Certification and Outpatient pre-certification should take place prior to a planned admission or listed Outpatient procedure.. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section ***"Hospitalization Utilization Review Program"*** **and "Outpatient Pre-Certification"** for details.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Durable Medical Equipment	90% after Deductible	80% after Deductible
Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses.	90% after Deductible, $50 Copay applies after Deductible is satisfied	90% after PPO Deductible, Usual and Customary and Reasonable apply, $50 Copay applies after Deductible is satisfied
Hearing Aids Children under 18 years of age – Limited to one aid per ear every 36 months. Also includes cochlear implants.	90% after Deductible	Not Covered
Hemodialysis	90% after Deductible	80% after Deductible
Home Health Care Services	90% after Deductible	80% after Deductible
Calendar Year maximum benefit	40 visits	
Hospice	90% after Deductible	80% after Deductible
Hospital Preadmission Testing	90% after Deductible	80% after Deductible
Hospital Physician Visits	90% after Deductible	80% after Deductible
Hospital Services	90% after Deductible	80% after Deductible
Maternity Services Maternity charges not included under the Preventive Services benefit.	90% after Deductible	80% after Deductible
Mental/Nervous Disorders and/or Substance Abuse Inpatient/Outpatient Treatment	90% after Deductible	80% after Deductible
Physician/Clinic Office Visit Includes office visit charge only.	90% after Deductible	80% after Deductible

Inpatient pre-admission certification and Outpatient pre-certification – This is a **voluntary program** that verifies the need for all Inpatient Hospital admissions and reviews the number of days requested for each admission and verifies the need for Outpatient chemotherapy/radiation therapy and dialysis.. Inpatient preadmission Certification and Outpatient pre-certification should take place prior to a planned admission or listed Outpatient procedure.. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section ***"Hospitalization Utilization Review Program"*** **and "Outpatient Pre-Certification"** for details.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Physician Fees for Surgical and Medical Services	90% after Deductible	80% after Deductible
Prescription Drugs Retail (90-day supply) Mail Order (90-day supply) Specialty Drugs (30-day supply)	 90% after Deductible 90% after Deductible 90% after Deductible	 80% after Deductible Not Covered Not Covered
Healthcare Reform (ACA) – Preventive drugs are covered at 100%, not subject to deductible or coinsurance (Generic and single source Brand only).		
If you are without your ID card or use a non-participating pharmacy, you must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the plan, reimbursement will be based on 100% of submitted charges less the applicable deductible/coinsurance.		
Preventive Care Services Preventive services included under Healthcare Reform. *To comply with statutes and regulations, preventive services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	80% after Deductible Immunizations for ages 6 and under are paid at 100% Deductible waived
Preventive Care Services All other preventive services not included under Healthcare Reform. *See the Covered Expenses section for those services.*	100% Deductible waived	80% after Deductible
Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition, except as specifically provided under the Plan.		

Inpatient pre-admission certification and Outpatient pre-certification – This is a **voluntary program** that verifies the need for all Inpatient Hospital admissions and reviews the number of days requested for each admission and verifies the need for Outpatient chemotherapy/radiation therapy and dialysis.. Inpatient preadmission Certification and Outpatient pre-certification should take place prior to a planned admission or listed Outpatient procedure.. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section ***"Hospitalization Utilization Review Program"*** **and "Outpatient Pre-Certification"** for details.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Preventive Care Services Breast Pump	100% Deductible waived	80% after Deductible
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		
Skilled Nursing Facility	90% after Deductible	80% after Deductible
Per confinement maximum benefit	120 days	
Surgery Inpatient/Outpatient	90% after Deductible	80% after Deductible
Temporomandibular Joint Disorder Services	90% after Deductible	80% after Deductible
The Joyful Doc Clinic Services	Covered services, including prescription drugs, received from providers at The Joyful Doc Clinic will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.	
Therapy Services	90% after Deductible	80% after Deductible
Transplants	90% after Deductible	80% after Deductible
Urgent Care Includes facility charge, Physician charge and other urgent care expenses.	90% after Deductible	80% after Deductible
Virtual Care	90% after Deductible	Not Covered
X-ray, Laboratory and Pathology Services	90% after Deductible	80% after Deductible
All Other Covered Expenses	90% after Deductible	80% after Deductible

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

You are eligible for medical coverage if you are Legally Employed and regularly scheduled to work as a full-time Employee. If you are no longer regularly scheduled to work, you will cease to be a covered Employee under this Plan.

An Employee shall be deemed regularly scheduled to work if the Employee is absent from work due to a health factor. An Employee shall be deemed regularly scheduled to work on any Employer-approved holiday or vacation provided that the Employee was working on his last regularly scheduled working day before such vacation or holiday. In no event will an Employee be considered regularly scheduled to work if he has effectively terminated employment.

The following classes of Employees are also included as eligible Employee classes for coverage:

A. Non-Variable Hour Employees who work scheduled daily shifts of less than six hours per day during the school year provided the Employee pays the full cost of the existing premium.

B. Non-Variable Hour Employees who work at least six (6) hours per day / thirty (30) hours per week or 130 hours per month during the school year, covered at the full cost of premium.

C. Teachers who hold less than a half-time teaching position provided the teacher pays the full cost of the existing premium. Teachers working half-time or more will have their benefits prorated.

D. If the Employee is a Variable Hour Employee in no event shall the amount of time worked average less than thirty (30) hours per week or 130 hours per month during a completed Measurement Period. A Variable Hour Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an Employee in accordance with the Affordable Care Act (ACA) as amended.

The following Employees shall not be eligible Employees: i) leased Employees, as defined in Code Section 414(n), ii) individuals classified by the Employer as temporary Employees due to their limited work assignment which will not exceed 90 days, iii) individuals classified by the Employer as independent contractors or leased Employees (including those who are at any time reclassified as Employees by the Internal Revenue Service or a court of competent jurisdiction).

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first day of the month following thirty (30) days of regular employment with the Chippewa Falls Area Unified School District, providing you enroll for coverage within (30) days following the completion of the Waiting Period unless you are a Variable Hour Employee.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

If you do not apply to become a covered Employee by completing an enrollment form or application within the thirty (30) day period following the Waiting Period, you will only be able to enroll under this Plan during a Special Enrollment Period or Open Enrollment. This Plan will be effective on the first of the month following receipt of your enrollment form or application.

In some cases, there may be "special" circumstances that will allow an Employee to enroll for coverage. For further details on these circumstances, see the section on Special Enrollment Periods.

If you cease employment due to layoff or authorized leave of absence, participation may be continued pursuant to rules adopted by the committee and applied to all covered Employees similarly situated on a uniform basis. Notwithstanding the foregoing provision, participation may be continued for a covered Employee on an approved Disability leave of absence pursuant to rules adopted by the committee and applied on a uniform basis to all covered Employees similarly situated.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

A. the date on which the Non-Variable Employee ceases to be in a class of Employees eligible for coverage;

B. the date following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period;

C. the date this Plan is amended to terminate the coverage of a class of Employees of which you are a Participant;

D. the end of the period for which you have made contributions if you fail to make the next required contribution;

E. the date this Plan is terminated with respect to the School District; and there is no successor plan;

F. the date you voluntarily elect to be terminated from this Plan subject to the pre-tax premium rules as outlined in this Plan.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any medical services after the termination date even though these services are furnished as a result of an Injury or Illness that occurred prior to the termination of coverage.

REINSTATEMENT OF COVERAGE

An Employee who is terminated and rehired will be treated as a New Employee upon rehire and be subject to all New Employee eligibility and waiting period requirements only if the Employee was not credited with an Hour of Service with the Employer for a period of at least 26 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as an Ongoing Employee upon rehire only if the Employee break in service did not exceed 26 weeks.

Upon return, coverage will be effective on the date of return so long as all other eligibility criteria are satisfied.

Employees returning from an approved leave of absence or temporary layoff of less than 26 weeks and who did not continue coverage will be effective on the date of return so long as all other eligibility criteria are satisfied (any applicable waiting period is waived). Employees returning from an approved leave of absence or temporary layoff exceeding 26 weeks and who did not continue coverage will be subject to all New Employee eligibility and waiting period requirements.

RETIREE ELIGIBILITY

Retired Employees of Chippewa Falls Area Unified School District and their covered dependents are eligible for medical and prescription drug coverage if **each** of the following conditions is met:

A. the terms and conditions of eligible retirement as outlined in the individual contracts, if applicable, or Employee handbook;

B. any required contributions have been made; and,

C. all Medicare entitled programs are elected by retired Employees with a retirement date on or after June 1, 2014. Retired Employees with a retirement date prior to June 1, 2014 are not subject to this requirement in order to be an eligible Retiree.

RETIREE ENROLLMENT AND EFFECTIVE DATE

Retired Employees and their covered dependents are eligible to continue coverage under this Plan provided each of the conditions listed in the previous section are met.

Furthermore, on the date of retirement, coverage will continue as long as the Retiree has elected to continue this coverage and there is no break in coverage.

RETIREE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

A. the date the covered Retiree ceases to be in a class of Retirees eligible for coverage;

B. the date this Plan is terminated with respect to an entire class of Retirees to which such covered Retiree belongs for coverage;

C. the end of the period for which the covered Retiree has made contributions if the covered Retiree fails to make the next required contribution;

D. the date this Plan is terminated with respect to the company, and there is no successor plan;

E. the date the Retiree knowingly misrepresents/falsifies information to the Plan;

F. the date the covered Retiree voluntarily elects to be terminated from the Plan;

G. the date the covered Retiree turns age 65.

DEPENDENT ELIGIBILITY

A covered Employee may choose to cover his/her dependents (as defined) under this Plan.

A. your lawfully married Spouse possessing a marriage license who is not divorced from the Employee;

B. each newborn Child of the Employee subject to the following:
   1. a newborn Child shall be considered a covered individual from and after the time of birth as to Covered Expenses which are due directly to:
      a. Injury or Illness;
      b. premature birth;
      c. a condition which exists at birth; and
   2. also, a newborn Child, born while the mother is covered, who becomes covered as a dependent in accordance with the terms of the Plan, shall be covered for:
      a. routine Room and Board (or nursery) charges;
      b. routine Physician visits;
      c. circumcision;

C. a covered Employee's dependent Child may be covered until the dependent reaches their 26th birthday regardless of marital status;

D. a covered Employee's dependent Child may be covered if all of the following conditions are met:
   1. a Full-Time Student regardless of age; and,
   2. was under the age of 27 when called to federal Active Duty in the National Guard or in a reserve component of the U.S. armed forces while a Full-Time Student at an institution of higher education;

E. a covered Employee's dependent grandchild(ren) are eligible for coverage under this Plan until your dependent Child reaches age 18 or marries, whichever occurs first.

If both parents are covered under this Plan as Employees, a Child can be covered as a dependent of only one parent. No one covered under this Plan as an Employee can also be covered as a dependent.

QMCSO Provision

This Plan will provide benefits to dependent children of a divorced Participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the Child(ren) reside with the Participant. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirement

Within a Reasonable period of time following receipt of a medical Child support order, the Plan Administrator will notify the Participant and each Child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an Alternate Recipient (Participant's Child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the Alternate Recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order, the medical Child support order must contain the following information:

A. the name and last known mailing address of the Participant and the name and address of each Child to be covered by this Plan.

B. a Reasonable description of the type of coverage to be provided by this Plan to each named Child, or the manner in which the type of coverage is to be determined.

C. the period to which such order applies.

If the order **is** determined to be a Qualified Order, each named Child will be covered by this Plan in the same manner as any other dependent Child is covered by this Plan.

Coverage for a Child under a QMCSO will begin on the latest of the following date:

A. If the Employee already has coverage in force, the Child will be covered as of the date specified in the order, if no date is specified in the order, the date the QMCSO is received;

B. If the Employee is within the Waiting Period as specified under the section entitled "Effective Date" the Child will become effective the same date the Employee's coverage is effective; or

C. If the Employee is otherwise eligible but previously waived coverage, the Employee's and the Child's coverage will become effective as of the date specified in (A.) above.

Each named Child will be considered a Participant under the Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named Child.

If it is determined that the order **is not** a Qualified Order, each named Child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, Effective Date and termination provisions will apply.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of an unmarried dependent Child shall not cease because of attainment of the termination age specified in the Plan, while your coverage is in force and the Child otherwise qualifies as a dependent, if the Child:

A. is unmarried; and

B. is determined to be an Incapacitated Person, incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical Disability; and

C. became so disabled prior to attainment of the termination age specified in this Plan.

You must submit to the School District, within thirty (30) days of such dependent's attainment of the termination age, written proof of the Disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

The School District, upon receipt of proof of the Disability, shall have the right and opportunity to have a Physician it designates examine any such dependent when and as often as the School District may reasonably require. The School District will not require the dependent to be examined more than once each year after such Disability has continued on an uninterrupted basis for at least two (2) years following the date the initial written proof of Disability was received by the School District.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

A. the date the dependent's Disability as described no longer exists;

B. the date the dependent fails to submit to any required medical examination;

C. the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan; or

D. the date you fail to submit any required proof of the uninterrupted existence of the dependent's Disability.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for your dependents will become effective on the same date the Employee's coverage begins. Any new dependent can become a covered dependent as one of the following applicable dates:

A. the eligibility date for which written application is made and delivered to the Plan Administrator by you, if made on or before the date the individual becomes a dependent;

B. The eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator by you within thirty (30) days after the individual becomes a dependent; or

C. The eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period. For further details on these circumstances, see the section on **Special Enrollment Periods.**

DEPENDENT TERMINATION OF COVERAGE

Dependents' coverage will end on the earliest of the following dates:

A. the date on which your coverage the date on which he/she ceases to be a dependent, as defined by this Plan;

B. the end of the period for which you have made contributions for a dependent's coverage if you fail to make the next required contribution;

C. in the event of a legal separation or divorce, coverage for your Spouse will cease on the date in which the event occurred;

D. the date the covered dependent, other than a dependent Child, ceases to be in a class of dependents eligible for coverage;

E. the end of the month the covered dependent Child ceases to be eligible for coverage;

F. the date this Plan is terminated with respect to the School District, and there is no successor plan;

G. the date the Retiree turns age 65;

H. the date the covered dependent voluntarily elects to be terminated from this Plan subject to the pre-tax premium rules as outlined on in this Plan; or

Unless otherwise specified under this Plan, when coverage terminated, benefits will not be provided for any medical services after the termination date even though these services are furnished as a result of an Injury that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current Employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent. These special enrollments rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity.

No plan election changes are permitted with this Plan. An Employee who is presently enrolled under one Plan option may not elect to become enrolled in an alternate Plan option if there are alternate plan options offered by the Employer.

Individuals Losing Other Coverage

This Plan will permit a current Employee or dependent that is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

A. the current Employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;

B. the current Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current Employee having coverage under another group health plan or due to the Employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current Employee with notice of the requirement (and consequences of the requirement) at that time;

C. the current Employee or dependent lost other coverage pursuant to one of the following events:

1. the current Employee or dependent was under COBRA and the COBRA coverage was exhausted;

2. the current Employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);

3. the current Employee or dependent moved out of an HMO service area with no other option available;

4. the Plan is no longer offering benefits to a class of similarly situated individuals

5. the benefit package option is no longer being offered and no substitute is available; or

6. the Employer contributions were terminated; and

D. under the terms of this Plan, the current Employee requests enrollment into this Plan not later than thirty (30) days after an event, as described in (c) above.

For an eligible current Employee or dependent who has met **each** of the conditions specified above, this Plan will be effective on the date the other coverage was lost.

This Plan will also permit a current Employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current Employee or dependent lost eligibility under Medicaid or Children's Health Insurance Program (CHIP).

The current Employee must request enrollment into this Plan not later than 60 days after the event, as described above.

For an eligible current Employee or dependent who has met the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within the required days from loss of coverage.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current Employee (and, if not otherwise enrolled, the current Employee, Spouse and/or other eligible dependent may be enrolled at the same time):

A. if the current Employee has coverage under this Plan (or the current Employee has met any Waiting Period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and

B. if a person becomes a dependent of the current Employee through marriage, legal guardianship, a foster Child being placed with the Employee, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a Child, the Spouse and/or other dependents of the current Employee may also be enrolled as a dependent if the Spouse and/or other eligible dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of thirty (30) days beginning on the date of marriage, legal guardianship, a foster Child being placed with the Employee, birth, adoption or placement for adoption.

If the covered current Employee has family coverage, newborns are automatically covered under this Plan from the moment of birth. An enrollment form or application will not be required, but the Employee must notify the Plan no later than thirty (30) days after the birth (dependent special enrollment period). If notification is not given to the Plan within thirty (30) days, the newborn's coverage will end on the 31st day after birth.

If a current Employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

A. in the case of marriage, the first of the month coincident with or next following the date of the marriage;

B. in the case of a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child;

C. in the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction;

D. in the case of a dependent's birth, as of the date of birth; or

E. in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current Employee (and, if not otherwise enrolled, the current Employee, Spouse and/or other eligible dependent may be enrolled at the same time) if:

A. the current Employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP).

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility. [Flexible spending plans and high deductible health plans are not eligible for this special enrollment period.]

If a current Employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective as of the first day of the month after the request for enrollment is received.

OPEN ENROLLMENT PERIOD

The School District will offer an annual enrollment period during which an Employee may elect to participate in the Plan. Any otherwise eligible Employee who has previously waived coverage may elect to participate provided he/she applies during this enrollment period. The enrollment period will be held annually during the month of May with a July 1 Effective Date.

No plan election changes are permitted with this Plan. An Employee who is presently enrolled under one Plan option may not elect to become enrolled in an alternate Plan option if there are alternate plan options offered by the Employer.

EXTENDED BENEFITS

If you are Totally Disabled as a result of an Injury or Illness which the Plan covers on the date you terminate coverage, you will continue to be covered until the earliest of:

A. the date your Physician certifies you are no longer Totally Disabled; or

B. the end of twelve (12) consecutive months immediately following the date of your termination of coverage.

The extended benefits provision applies only to Covered Expenses for the disabling condition which existed on the date your coverage terminated.

GINA

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

The term "Genetic Information" means, with respect to any individual, information about:

A. Such individual's genetic tests;

B. The genetic tests of family members of such individual; and

C. The manifestation of a disease or disorder in family members of such individual.

The term "Genetic Information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Genetic Information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting condition limitations. Offering reduced premiums or other rewards for providing Genetic Information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services Secretary of its activities falling within this exception.

While the Plan may collect Genetic Information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon Genetic Information request or require genetic testing or collect Genetic Information either prior to or in connection with enrollment or for underwriting purposes.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered Employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered Employee may elect to continue such coverages in effect at the time the Employee is called to active service. The maximum period of coverage for the Employee and the covered Employee's dependents under such an election shall be the lesser of:

A. the twenty-four (24) month period beginning on the date on which the covered Employee's absence begins; or

B. the period beginning on the date on which the covered Employee's absence begins and ending on the day after the date on which the covered Employee fails to apply for or return to a position of employment as follows:

   1. for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight (8) hours after a period allowing for the safe transportation from the place of service to the covered Employee's residence or as soon as reasonably possible after such eight (8) hours period;

   2. for service of more than thirty (30) days but less than one hundred either one (181) days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;

3. for service of more than one hundred either (180) days, no later than ninety (90) days after the completion of the period of service; or

4. for a covered Employee who is hospitalized or convalescing from an Illness or Injury Incurred in or aggravated during the performance of service in the Uniformed Services, at the end of the period that is necessary for the covered Employee to recover from such Illness or Injury. Such period recovery may not exceed two (2) years.

A covered Employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the Employer's other Employees, except that in the case of a covered Employee who performs service in the Uniformed Services for less than thirty-one (31) days, such covered Employee may not be required to pay more than the Employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as Active Duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered Employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former Employer, will apply.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This section only applies to Employers required to comply with the Federal Family and Medical Leave Act of 1993, as amended.

Entitlement to Leave

This Act requires an employer which employs fifty (50) or more Employees (within a seventy-five (75) mile radius) to allow an Employee who has been employed for twelve (12) months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of twelve (12) weeks of leave during any twelve (12) month period, as defined by the Employer, for:

A. the birth of a son or daughter of the Employee and in order to care for such one or daughter;

B. placement of a son or daughter with the Employee for adoption or foster care;

C. care for a Spouse, son, daughter, or parent of the Employee, if such Spouse, son, daughter, or parent has a serious health condition;

D. a serious health condition that makes the Employee unable to perform the functions of the position of such Employee; or

E. a qualifying exigency arising out of the fact that the Spouse, son, daughter, or parent of the Employee is on Active Duty (or has been notified of an impending call or order to Active Duty) in the Armed Forces in support of a Contingency Operation.

Expiration of Entitlement

The entitlement to leave under subparagraphs (A) and (B) of Entitlement of Leave for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

Servicemember Family Leave

An eligible Employee who is the Spouse, son, daughter, parent or Next of Kin of a Covered Servicemember shall be entitled to a total of twenty-six (26) workweeks of leave during a single twelve (12) month period to care for the servicemember. The leave described in this paragraph shall only be available during a single twelve (12) month period.

Combined Total Leave

During the single 12-month period as described in Service-member Family Leave, an eligible Employee shall be entitled to a combined total of twenty-six (26) workweeks of leave under Entitlement to Leave and Service-member Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other twelve (12) month period.

Any Employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The Employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the Employee had remained employed. If the Employee who is responsible for payment misses a premium payment during the leave of absence, the Employer may terminate coverage provided that the Employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the Employee is entitled to be fully reinstated upon returning to work. If the Employee for any reason fails to return from the leave, the Employer may recover from the Employee the premium or portion of the premium that the Employer paid, provided the Employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the Employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the Employee is not returning to work. Therefore, if an Employee does not return at the end of twelve (12) weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993, as amended. Please contact the Employer for more information.

COVERAGE CONTINUATION UNDER FEDERAL LAW – COBRA

The following information about the Participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. COBRA coverage can become available to the Participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the Participant's Spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the Participant and his/her family, and what the Participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan and not to any other benefits offered under the Plan or by Chippewa Falls Area Unified School District (such as life insurance, Disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Chippewa Falls Area Unified School District, which is the Plan Administrator.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." The Participant, his/her Spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and Alternate Recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other Participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other Participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this Plan.

Who is Entitled to Elect COBRA?

The Employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the Spouse of an Employee, the Spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

A. the Employee dies;

B. the Employee's hours of employment are reduced;

C. the Employee's employment ends for any reason other than his or her gross misconduct;

D. the Employee becomes entitled to Medicare benefits prior to his/her qualifying event; or

E. the Spouse becomes divorced or legally separated from the Employee.

As the dependent Child of an Employee, the dependent Child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

A. the parent-Employee dies;

B. the parent-Employee's hours of employment are reduced;

C. the parent-Employee's employment ends for any reason other than his or her gross misconduct;

D. the parent-Employee becomes entitled to Medicare benefits;

E. the parents become divorced or legally separated; or

F. the dependent stops being eligible for coverage under the Plan as a "dependent Child."

If an Employee takes FMLA Leave and does not return to work at the end of the leave, the Employee (and the Employee's Spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA Leave began (or became covered during the FMLA Leave); and (2) they will lose Plan coverage because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA Leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA Leave, with the same eighteen (18) month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

When is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries. The Participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a dependent Child's losing eligibility for coverage as a dependent Child), a COBRA election will be available only if the Participant notifies the Plan Administrator in writing within sixty (60) days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the Employee's name, the Employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed, or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

Electing COBRA Coverage

To elect COBRA, the Participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Plan Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The Participant may also obtain a copy of the Election Form from the Plan Administrator. Under federal law, the Participant must have sixty (60) days after the date the qualified beneficiary plan coverage terminates, or, if later, sixty (60) days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

Chippewa Falls Area Unified School District
1130 Miles Street
Chippewa Falls, WI 54729

The Election Form must be completed in writing and mailed to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than sixty (60) days after the date of the COBRA election notice provided at the time of the qualifying event. **IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the Participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnished a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

The Participant does not have to send any payment with his/her Election Form when he/she elects COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the Employee's Spouse may elect COBRA even if the Employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered Employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the sixty (60) day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the Participant completes the Election Form, he/she must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the Participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that Other Plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, the Participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having preexisting condition exclusions applied to the Participant by other group health plans if he/she has a sixty-three (63) day gap in health coverage, and election of COBRA may help not have such a gap. Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if he/she elects COBRA coverage and does not exhaust COBRA coverage for the maximum time available. Finally, The Participant should take into account that he/she has special enrollment rights under federal law. The Participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the Spouse's employer) within thirty (30) days after the Participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The Participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the Employee, the covered Employee's divorce or legal separation, or a dependent Child's loss of eligibility as a dependent Child, COBRA coverage can last for up to a total of thirty-six (36) months.

When Plan coverage is lost due to the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to thirty-six (36) months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his Spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of eighteen (18) months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in the Participant's COBRA election was the covered Employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The Participant must notify the Plan Administrator of a Disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a Disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a Disability, the qualified beneficiary must also supply a copy of the Social Security Administration Disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the Participant notifies the Plan Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first sixty (60) days of COBRA coverage. Each qualified beneficiary will be entitled to the Disability extension if one of them qualifies.

The Disability extension is available only if the Participant notifies the Plan Administrator in writing of the Social Security Administration's determination of Disability within sixty (60) days after the latest of:

A. the date of the Social Security Administration's Disability determination;

B. the date of the covered Employee's termination of employment or reduction of hours; or

C. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the Employee's name, the Employee's Social Security Number, the dependent's name and a description of the event.

The Participant must also provide this notice within eighteen (18) months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a Disability extension.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period and within eighteen (18) months after the covered Employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a Disability extension, the twenty-nine (29) months) following the covered Employee's termination of employment or reduction of hours. The Maximum Amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a covered Employee, divorce or legal separation from the covered Employee or a dependent Child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare.)

The extension due to a second qualifying event is available only if the Participant notifies the Plan Administrator in writing of the second qualifying event within sixty (60) days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the Disability extension period will end the first of the month beginning more than thirty (30) days following recovery.

Example: If Disability ends June 10, coverage will continue through the month of July (7/31).

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

A. any required premium is not paid in full and on time;

B. a qualified beneficiary becomes covered, after electing COBRA, under another group health plan; (but only after any preexisting condition exclusion of that Other Plan for a preexisting condition of a qualified beneficiary have been exhausted or satisfied);

C. a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;

D. the Employer ceases to provide any group health plan for its Employees; or

E. during a Disability extension period, the disabled qualified beneficiary is determined by Social Security Administration to be no longer disabled. For more information about the Disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be termination for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA coverage (such as fraud).

The Participant must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. (but only after any preexisting condition exclusions of that Other Plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the Participant provides notice to the Plan Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the Participant must notify the Plan Administrator of that fact within thirty (30) days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a Disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than thirty (30) days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Chippewa Falls Area Unified School District will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the Participant provides notice to the Plan Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the Disability extension period, see the section above entitled "Extension of Maximum Coverage Period).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a Disability, 150%) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The Participant will be notified of COBRA premium changes.

Payment for COBRA Coverage

All COBRA premiums must be paid by check or money order.

The Participant's first payment and all monthly payments for COBRA coverage must be made payable to Chippewa Falls Area Unified School District and mailed to:

Chippewa Falls Area Unified School District
1130 Miles Street
Chippewa Falls, WI 54729

The payment is considered to have been made on the date that it is postmarked. The Participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the Participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than forty-five (45) days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the Participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election. The Participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Plan Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the Participant has elected COBRA and has made the first payment for it.

If the Participant does not make the first payment for COBRA coverage in full within forty-five (45) days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the Participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the Participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the Participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the Participant will be given a grace period of thirty (30) days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of that month's grace period. However, if the Participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim(s) submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the Participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

More Information About Individuals Who May be Qualified Beneficiaries

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a qualified medical Child support order (QMCSO) received by the Chippewa Falls Area Unified School District during the covered Employee's period of employment with Chippewa Falls Area Unified School District is entitled to the same rights to elect COBRA as an eligible dependent Child of the covered Employee.

Continuation During Family and Medical Leave Act (FMLA) Leave

The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or they have any questions they may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

Assistance with Questions

Questions concerning the Plan or the Participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), as amended, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan Informed of Address Changes

In order to protect the Participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The Participant should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

Plan Contact Information

The Participant may obtain information about the Plan and COBRA coverage on request from:

Chippewa Falls Area Unified School District
1130 Miles Street
Chippewa Falls, WI 54729

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the Participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows you to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that you would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that you pay no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions you make. Furthermore, your premium is also exempt from state income taxes in most states. This means a higher take-home pay for you, than if you purchased this Plan with after-tax dollars.

Note: Because the premium contributions you make to this Plan are not taxed as wages for Social Security purposes, your ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including your earnings history, whether you are above or below the Social Security "wage base," and what happens to the Social Security laws between now and when you retire.

The pre-tax premium program is available to you if you meet the eligibility requirements under this Plan. Your premium will automatically be deducted from your paycheck on a pre-tax basis. If you desire your premiums be paid on an after-tax basis, you must notify Human Resources. Your enrollment regarding the tax status of your premiums will continue in effect until you change it. You can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if you experience a family status change, as defined by the Internal Revenue Service.

Your choices are in effect for the entire Plan Year. Only under special circumstances, such as changes in family status (including, but not limited to marriage, divorce, legal separation, death of a Spouse or Child, birth or adoption of a Child, the termination or commencement of your Spouse's employment, a significant increase in your costs with respect to this Plan, the switching from part-time to full-time employment status or the reverse by you or your Spouse or the taking of an unpaid leave of absence by you or your Spouse), may you apply to change your selected benefits. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

HOSPITALIZATION UTILIZATION REVIEW PROGRAM

HOW THE PROGRAM WORKS

THIS IS A VOLUNTARY PROGRAM

ADMISSION CERTIFICATION

A. **"ELECTIVE ADMISSIONS"** or non-Emergency Hospital treatment is medical care that is scheduled several days in advance, usually at a time convenient for both you and your Physician.

When your Physician is scheduling an elective Hospital admission, **CALL THE 800-NUMBER LISTED ON YOUR HEALTH BENEFITS IDENTIFICATION CARD FOR ADMISSION CERTIFICATION** at least one week before the Hospital admission.

You, your Physician, the Physician's staff or even a family member may call for admission certification.

REMEMBER: Notification of admission must be obtained within the required time frame to assure maximum benefits coverage.

B. **"URGENT ADMISSIONS"** or urgent Hospital treatment is medical care that requires immediate attention but is not considered a life-threatening situation. For urgent admissions, **if there is time**, you follow the same procedures as with an elective admission; **if there is not time**, follow the same procedures as with an Emergency admission.

C. **"EMERGENCY ADMISSIONS"** or hospitalizations for potentially life-threatening causes are exempt from the pre-admission certification requirement. However, following an Emergency admission, certification must be obtained within **two (2) business days** following the admission or on the first business day following weekend or holiday admission.

D. **"PREGNANCY"** notification to the 800-NUMBER should be made as soon as your Physician has confirmed that you are pregnant, within the first three months. A representative will ask you some questions regarding any previous pregnancies, your medical history and behaviors that may affect your baby. (Notification to the 800-NUMBER at the time of delivery and/or if you are hospitalized at any time during the pregnancy is also recommended.)

OUTPATIENT PRE-CERTIFICATION

The following services should be pre-certified:

A. Outpatient chemotherapy/radiation therapy at a facility or Physician's office.

B. Outpatient dialysis.

HOW THE MEDICAL PLAN WORKS

DESCRIPTION OF MEDICAL BENEFITS

Individual Deductible

If you have individual coverage, unless otherwise specified, you will be responsible for individual Calendar Year deductible amount specified in the schedule of benefits before any benefits will be paid by this Plan.

Family Deductible

If you choose to take family coverage, each covered family member only needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to receiving plan benefits. For example, if there is a family Deductible of $3,000 with an individual Embedded Deductible of $1,500, then when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

Coinsurance

Once you have paid your Calendar Year deductible, this Plan will pay the coinsurance percentages outlined in the schedule of benefits.

Maximum Out-of-Pocket

There are limits on how much you will have to pay per individual, or per family, in allowable medical expenses per Calendar Year. The schedule of benefits specifies what the maximum out-of-pocket includes and what it excludes. The maximum out-of-pocket never includes ineligible charges. Once you meet the maximum out-of-pocket, this Plan pays 100% of the Allowable Expenses.

COMPREHENSIVE MEDICAL COVERAGES

You will notice that some of the terms used in this Plan begin with a capital letter. For a detailed explanation of these terms, please refer to the **DEFINITIONS** Section.

Comprehensive Medical Expense Coverage Clause

Subject to the provisions, exceptions and limits of the policy, the benefits, as shown below, are payable for Medically Necessary Covered Expenses Incurred by a covered individual while covered for this benefit if:

A. the deductible and coinsurance requirements, if any, are met;
B. Covered Expenses are prescribed by a Physician for the treatment of Injury or Illness. Preventive Care services will not be considered eligible Covered Expenses unless the Plan specifically provides for medical treatment, services or supplies solely for the purpose of Preventive Care and not for the treatment of an Illness or Injury;
C. are not more than the Usual and Customary fees;
D. are not excluded under the exceptions provisions of the policy.

Provider Provisions

A. Expenses for obtaining medical records will be paid in full to a maximum benefit of $100.00 per provider.
B. Due to the constant changes to the provider network, it is always a good idea to verify that your provider is still part of the network at the time you make your appointment.
C. Preferred Providers are not subject to Usual and Customary fees. Non-Preferred Providers are subject to Usual and Customary fees and any charges in excess of Usual and Customary will not be considered eligible for payment.

Services and Supplies

The Plan is a cost sharing mechanism for certain health services and supplies utilized by a Participant. The Plan is not responsible for the efficiency and integrity of the health providers delivering such health services and supplies. The Plan is not liable in any way for the effect of delivery of such health services and supplies or the results of action taken as a result of a health service and supply being limited or not covered by the Plan.

Right to Consider Substitution for Covered Charges

The Claims Administrator shall have the right to consider alternate charges Incurred for treatment, services or supplies not specifically listed as covered charges for payment of benefits under this Plan. The charges will be considered at the Plan Administrator's sole option and:

A. must have the knowledge and consent of the covered individual Participant; and
B. must be prescribed and approved by the Physician and be generally accepted and approved by the medical profession; and
C. must offer a medical therapeutic value equal to the treatment or service that would otherwise be performed or given; and
D. must be Medically Necessary.

The Plan Administrator may cease to pay benefits for these substitute treatments, services or supplies at any time with written notification to the covered participant.

Balance Billing

In the event that a claim submitted by a Preferred or non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Preferred Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Preferred Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Preferred Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Preferred Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred Provider.

The Participant is responsible for any applicable payment of coinsurances, deductibles and out-of-pocket maximums and may be billed for any or all of these.

COVERED EXPENSES

The Claims Administrator will consider each expense to be Incurred on the date the medical care or supply is received:

A. Charges for semi-private accommodations for an unlimited number of days. Private room and Intensive Care or Special Care Unit accommodations are covered if Medically Necessary. If a private room is occupied but not Medically Necessary, the average charge for a semi-private room will be paid.

B. Charges for Pre-Admission Testing (screening x-rays and lab tests) which is done right before a pre-scheduled Inpatient Hospital confinement.

C. Special Hospital charges for Inpatient medical care or supplies received during any period for which there are Room and Board charges.

D. Charges by a Hospital for Outpatient medical care received on an Outpatient basis and Outpatient medical supplies which are used on the premises of a Hospital.

E. Charges by an Ambulatory Surgical Center or Minor Emergency Medical Clinic, except services of a Physician or private nurse.

F. Surgery and Anesthesia charges of a Physician and for the giving of Anesthesia, however, charges which relate to cosmetic, plastic, reconstructive or restorative surgery shall be payable only if Incurred for the repair of a disfigurement caused from any of the following:
   1. an accidental Injury;
   2. a Birth Defect;
   3. as the result of a covered surgical procedure.

   The Plan will follow CMS Physician Fee Schedule and NCCI guidelines in determining procedures subject to multiple surgical procedure reductions.
   1. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedure; each additional procedure performed through the same incision will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
   2. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and
   3. If an assistant surgeon is required, the assistant surgeon's covered charge will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines.

G. Professional service charges for medical care and services made by a Physician, radiologist or pathologist, or by a laboratory for diagnostic laboratory and x-ray examinations.

   If multiple imaging/radiologic procedures are performed, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedures; Additional procedures will be allowed based on the CMS Payment Conditions for Radiology Services and NCCI guidelines.

H. Nutrition counseling as prescribed by a Physician, while confined as an Inpatient in a Hospital, under the supervision of or provided by a registered dietician.

I. Charges for the following providers:
   1. nursing services of an R.N., on their own behalf, in or out of a Hospital, if Medically Necessary;
   2. nursing services of an L.P.N. or L.V.N., on their own behalf, in a Hospital, if such services are prescribed by a Physician;
   3. services of a qualified Speech Therapist if such charges are made for Speech Therapy used for the purpose of restoring speech loss or correcting damage which:
      a. is due to an Illness, other than a non-organic/functional disorder or surgery due to such Illness; or
      b. follows surgery to correct a Birth Defect;
   4. Physical, Occupational and respiratory therapy performed by a Physician or licensed Physical, Occupational or respiratory therapist. The therapist must be providing the therapy under the direction of a Physician. Charges for pool therapy, aquatic therapy and hydrotherapy is also recognized as Physical Therapy when performed by a Physical Therapist or other recognized licensed provider for Physical Therapy modalities, administered in a pool; which requires direct one-on-one patient contact. The therapist must be providing the therapy under the direction of a Physician for a condition that is Medically Necessary, Reasonable and appropriate for Physical Therapy treatment. Therapy will end when:
      a. treatment goals have been reached; or
      b. no substantive change is seen by the patient's condition after a reasonable period; or
      c. maximum medical improvement has been reached.
   5. other provider of service, as determined eligible by the Plan and subject to Medical Necessity, who is duly licensed, if applicable, by the state or regulatory agency responsible for such licensing in the state in which the individual performs services.

   A nurse or therapist must not be a Close Relative or one who has the same legal residence as the covered individual.

J. Covered Expenses for pregnancy will be payable on the same basis as Covered Expenses for any other Illness with respect to a female Employee and dependent wife. Benefits will also be payable for any expenses which relate to pregnancy of a dependent Child. A grandchild of the Employee will be covered only if the grandchild satisfies eligibility requirements and meets the definition of Child.

   Any benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child may not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the plan may not, under Federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

K. Home Health Care is covered by the Plan if approved in writing by an attending Physician as follows:

1. part-time nursing care or home health aide services Medically Necessary and under the supervision of or provided by a Registered Nurse or medical Social Worker;
2. Physical, respiratory, Occupational or Speech Therapy;
3. medical supplies, drugs and medications (refer to prescription drug benefit) prescribed by a Physician and laboratory services provided by or on behalf of a Hospital. These items are covered only if they would have been provided if confined in a Hospital;
4. nutrition counseling where necessary and under the supervision of or provided by a registered dietician;
5. evaluation for the need and the development of a plan made by a Registered Nurse, Physician extender or medical Social Worker;
6. each visit by any of the above providers is for up to 4 hours in any 24-hour period and up to a maximum of 40 visits per Calendar Year. In no event will more be paid than would have been paid had treatment been provided in a Skilled Nursing Facility during any weekly period.

The attending Physician must certify that home care services will be provided or coordinated by a state licensed or Medicare certified health agency or certified rehabilitation agency. Home care is not payable where treatment is available from family members without causing undue hardship. Family members mean your Spouse, children, parents, grandparents, brothers, sisters and their Spouses. (Benefits shall not include the transportation costs of the provider(s) of service.)

L. Transportation charges including commercial ground or air ambulance service to transport the patient:

1. to the nearest Hospital equipped to treat the specific Illness or Injury, in an Emergency situation; or
2. when Medically Necessary.

M. Hearing aids, cochlear implants and related treatment for dependent children. Must be prescribed by a Physician for an eligible Child under the age of 18 and who is certified as deaf or hearing impaired by a Physician or licensed Audiologist. Includes the cost of treatment related to hearing aids and cochlear implants including procedures for the implantation of cochlear devices. Limited to one hearing aid per ear once every three years.

N. Prescription Drugs and Medicines

Definitions apply to this benefit only:

Ancillary Charge: an additional charge will be required when the Participant chooses a brand medication for which a generic alternative is available. The Ancillary Charge is calculated as the difference between the brand medication and generic medication reimbursement rate for the Network Pharmacy.

Non-Participating Pharmacy: any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Prescription Legend Drug: any medicine if the Federal Food, Drug and Cosmetic Act requires its label to say, "Caution: Federal Law prohibits dispensing without prescription."

Prescription Order: the request a licensed Physician, dentist, or registered podiatrist, makes for medicine for a patient.

Provider: a pharmacy, Physician or other entity with a legal license or registration to dispense drugs participating in the prescription drug program.

Pharmacy Benefits Administrator: an organization that manages payment for Prescriptions and services under the Plan.

Drugs Covered

1. legend drugs. Exceptions: See Exclusion list below;
2. amphetamines;
3. anabolic steroids;
4. anorectics (any drug used for the purpose of weight loss);
5. antivirals, specifically indicated for the treatment of HIV/AIDS;
6. blood components and products including blood component injectables;
7. blood glucose monitors; ABBOTT products only;
8. *contraceptives, oral or other, whether medication or device. Over-the-counter (OTC) requires a prescription;
9. compounded medication of which at least one ingredient is a legend drug;
10. erectile dysfunction drugs, all dosage forms (Viagra is limited to 10 pills per 30 days);
11. *folic acid supplements. Over-the-counter (OTC) requires a prescription;
12. growth hormones;
13. *immunizations;
14. insulin;
15. disposable insulin needles/syringes;
16. insulin injection devices, disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape);
17. lancets;
18.. prenatal vitamins requiring a prescription;
19. *smoking deterrent medications. Over-the-counter (OTC) requires a prescription;
20. *aspirin to prevent cardiovascular disease. Over-the-counter (OTC) requires a prescription;
21. *aspirin to prevent preeclampsia. Over-the-counter (OTC) requires a prescription;
22. *bowel preps for use in colorectal cancer screening. Over-the-counter (OTC) requires a prescription;
23. *breast cancer chemoprevention medications;
24. *oral fluoride supplements. Over-the-counter (OTC) requires a prescription;
25. *vitamin D supplements. Over-the-counter (OTC) requires a prescription;
26. Tretinoin Topical (e.g., Retin-A);
27. female sexual dysfunction drugs, all dosage forms;
28. any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

* Type and dosage of medications, as well as age and gender criteria, are determined based on Affordable Care Act (ACA) requirements and recommendations by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) and Health Resources and Services Administration (HRSA). Contact your Pharmacy Benefit Manager for the most current listing of covered medications. Changes to the guidelines and recommendations will be adopted in compliance of the rules of the regulation.

Dispensing Limitations
The amount normally prescribed by a Physician but not to exceed a 90-day supply for retail or mail order. Specialty drugs will not exceed a 30-day supply regardless of whether they are retail or mail order.

Additional Charges
Your drug benefit program is designed to help restore your health by helping you receive the most effective, affordable medications to treat your medical condition or disease state. This Plan encourages you to obtain high-quality generic drugs. Generic drugs provide the same effectiveness and safety as your brand name counterparts, but save a substantial amount of money. If you request a brand name medication when there is a generic available, you will be required to pay the difference in cost between the generic and the brand medication (Ancillary Charge) in addition to the deductible and coinsurance if applicable.

Specialty Medications
Your pharmacy benefit program may include coverage for certain products that are referred to as Specialty Medications. Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan).

If you are unsure if your medication is considered a specialty drug, please call the NPS helpdesk at (800) 546-5677 for further clarification concerning your medication.

Most Specialty Medications are injectables; however, some may be oral or transdermal. Specialty Medications may be medications that you administer to yourself or have a healthcare provider administer to you. When a Physician administers a covered Specialty Medication, you may be responsible to procure the product and take to your appointment with you. If Specialty Medications are covered under your pharmacy benefit and you choose to have the medication administered at your Physician's office, you may be billed for an office visit in addition to your prescription.

Prior Authorization
To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the Participant's prescription drug benefit. To obtain a prior authorization, you or your pharmacy will need to contact the NPS helpdesk at (800) 546-5677 to request that a prior authorization be started for a specific medication. The helpdesk will need your Physician's name and fax number. The helpdesk will then fax a Coverage Determination Form to the doctor's office for the Physician to complete and fax back to NPS. Once the NPS clinical department has received the fax, they will have up to 48 hours to review the request.

Exclusions

1. anti-wrinkle agents (e.g., Renova) regardless of intended use;
2. contraceptive OTC methods, except specifically listed above in covered drugs;
3. dermatologicals, hair growth stimulants;
4. dietary supplements, except specifically listed above in covered drugs;
5. fluoride (topical fluoride dental products), other than those listed above;
6 immunization agents, blood or blood plasma, except specifically listed above in covered drugs;
7. infertility medications (e.g., Clomid, Metrodin, Perfonal, Profasi);
8. non-legend drugs other than those listed above;
9. vitamins, singly or in combination except specifically listed above in covered drugs;
10. smoking deterrent medications containing nicotine or any other smoking cessation aids, other than those listed above;
11. OTC Prilosec and equivalent agents; OTC Claritin and equivalent agents; OTC Zyrtec and equivalent agents; and OTC Zaditor and equivalent agents;
12. Ranitidine, Cimetidine and Famotidine;
13. therapeutic devices or appliances regardless of intended use except specifically listed above in covered drugs including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, other than those listed above;
14. any medication, legend or not, which is taken or administered at the place where it is dispensed;
15. charges for the administration of or injection of any drug, other than those covered under the preventive benefit;
16. drugs labeled "Caution – Limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the individual;
17. medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
18. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.

O. Charges (purchase or rental depending on economic justification) for orthopedic or prosthetic devices and hospital type equipment for:

1. man-made limbs or eyes for replacing natural limbs or eyes;
2. dressings, sutures, casts, splints, crutches or other necessary medical supplies;
3. purchase of a truss or brace as a direct result of:
   a. an Injury or Illness;
   b. a disabling condition existing since birth;
   with the exception of dental braces;
4. oxygen and other gases and their administration, rental of equipment for giving oxygen, rental of equipment to aid in breathing, iron lung or other Durable Medical Equipment required for temporary therapeutic use, wheelchair or hospital bed;
5. dialysis equipment rental, supplies, upkeep and the training of the covered individual or the one who attends him to run the equipment;
6. colostomy bags and ureterostomy bags;
7. custom-molded orthotics/orthopedic devices when determined to be Medically Necessary including, but not limited to, supports and in-shoe supports, orthopedic shoes, elastic supports or exams to prescribe or fit such foot devices, supports or shoes.

P. Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, subject to the following conditions:

1. a concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;
2. if the donor is covered under this Plan, eligible medical expenses Incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (5);
3. if the recipient is covered under this Plan, eligible medical expenses Incurred by the recipient will be considered eligible;
4. if both the donor and the recipient and covered under this Plan, eligible medical expenses Incurred by each person will be treated separately for each person;
5. the Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

If the recipient resides more than fifty (50) miles from the transplant site, costs for commercial transportation for the recipient and one companion are a covered benefit. Reasonable and necessary lodging and meal costs are also included.

Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature.

Some items **not** covered under transplant benefits are:

1. any services or supplies related to transplants involving mechanical organs; and
2. expenses associated with the purchase of any organ.

Q. Insulin infusion pumps, other equipment and supplies (which are not covered under the prescription drug program) including blood glucose testing monitors and diabetic self-management education programs. One pump is covered per year and the pump must be in use 30 days before purchase. For insulin and related supplies coverage, refer to prescription drug benefit.

R. Covered charges for skilled nursing care in a licensed Skilled Nursing Facility if you (anyone covered under the policy) are admitted to the nursing facility within 24 hours of discharge from one of the following: a general Hospital, a prior Skilled Nursing Facility or Outpatient observation (in lieu of Inpatient admission). Your admission to the Skilled Nursing Facility must be for the same condition treated in the Hospital, prior Skilled Nursing Facility or Outpatient observation. The Plan will pay benefits for up to 120 days per nursing facility confinement. The attending Physician must certify every seven days that the care is Medically Necessary and is not domiciliary or custodial.

S. Treatment of Nervous and Mental conditions and alcohol/drug dependency

1. **Inpatient Benefits**

   Payment will be made for Reasonable charges made by the Hospital, institution or facility for such care and treatment or by licensed professionals under the supervision of a Physician in connection therewith. Treatment includes residential treatment services.

2. **Outpatient Benefits**
   Payment will be made for Reasonable charges made by such Hospital, institution or Outpatient facility approved by the Department of Health and Social Services for such care and treatment or by a Physician, a Psychologist or a licensed certified Social Worker in connection therewith. Treatment includes but is not limited to partial confinement, prescribed drugs (refer to prescription drug benefit) and collateral family consultations.

T. Chiropractic therapy as follows:

Spinal manipulations and adjustments; Physical Therapy involving the spine; traction; inversion therapy; hot or cold packs; electric stimulation therapy; vaso-pneumatic devices; diathermy; therapeutic exercise; neuromuscular re-education; gait therapy; thermography; biofeedback therapy; hydrocollator therapy; and passive motion therapy.

Chiropractic care (exams, manipulations and adjustments) is limited to 18 visits per Calendar Year per participant.

U. Charges for Hospice care beginning on the date the attending Physician of a covered person certifies a diagnosis of terminally ill, and the covered person is accepted into a Hospice program. Hospice charges as follows:

1. nursing care by a Registered Nurse, a Licensed Practical Nurse, a Licensed Vocational Nurse or a public health nurse who is under the direct supervision of a Registered Nurse;
2. Physical Therapy and Speech Therapy when rendered by a licensed therapist;
3. medical supplies, including drugs and biologicals (refer to prescription drug benefit) and the use of medical appliances;
4. Physician's services;
5. services, supplies and treatments deemed Medically Necessary and ordered by a licensed Physician;
6. counseling for the patient and the patient's immediate family. Services must be given by a licensed Social Worker. For this benefit, "immediate family" means you or any member of your family who is covered under this Plan.

The "Hospice benefit period" is a specified amount of time during which the Covered Person undergoes treatment by a Hospice and shall end the earliest of the following:

1. six months from the date of acceptance into the Hospice program; or
2. the death of the Covered Person.

A new benefit period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new benefit period can begin.

V. Nurse-Midwife's services given by a licensed or certified Nurse-Midwife acting within the scope of that license or certification. The services do not have to be recommended and approved by a Physician. Benefits are payable on the same basis as covered services given by a Physician.

W. Services and supplies given in or by a Birth Center for care and treatment of pregnancy as follows:

1. Room and Board charged by a Birth Center;
2. charges for Other Services and Supplies;
3. Anesthetics and charges for giving them.

X. Charges for blood or blood plasma unless a refund or credit is made as a result of the operation of a group blood bank or similar organization.

Y. Charges for sterilization (refer to Preventive Care benefit section for female sterilization).

Z. Charges in connection with a mastectomy including:
1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce symmetrical appearance; and
3. coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas.

AA. Charges for infertility treatment are limited to the initial diagnosis and testing of infertility (the inability to conceive). Any treatment, drugs or procedures for the promotion of conception will not be considered eligible (i.e., in-vitro fertilization, GIFT, artificial insemination, etc.).

BB. The Plan shall cover services, supplies and treatments for Medically Necessary abortions when the life of the mother would be endangered by continuation of the pregnancy. Complications from an abortion shall be a Covered Expense whether or not the abortion is a Covered Expense.

CC. Contraceptives, whether medication or device, requiring a prescription, regardless of purpose. Prescription contraceptives that a Covered Participant self-administers will be processed under the prescription drug section of this Plan (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require a Physician to fit and/or administer a hormone shot or insert/remove a device) will be processed under the medical benefits of this Plan. Benefits are payable at 100% not subject to deductible or coinsurance when performed by a Preferred Provider.

DD. Charges for diagnostic procedures and Medically Necessary surgical and non-surgical treatment for the correction of temporomandibular disorders if all the following apply:
1. the condition is caused by congenital, developmental or acquired deformity, disease or Injury;
2. under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is Reasonable and appropriate for the diagnosis or treatment of the condition; and
3. the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Benefits for diagnostic and non-surgical treatment for the correction of temporomandibular joint disorders. Non-surgical treatment includes coverage for services such as prescribed intraoral splint therapy devices, trigger point injections and Physical Therapy.

Benefits are not payable for cosmetic or elective orthodontic care, periodontic care or general dental care.

EE. Charges for the following dental services including related x-rays, Anesthesia and consultations:
1. surgical removal of unerupted impacted wisdom teeth;
2. treatment of Injuries to natural teeth sustained in an Accident (Accident does not include dental conditions resulting from eating and/or biting);

3. excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
4. Hospital or Ambulatory Surgical Center charges Incurred and Anesthetics provided, in conjunction with dental care that is provided to a Participant in a Hospital or ambulatory surgery center provided:
    a. the Participant is a Child under the age of five;
    b. the Participant has a chronic Disability or medical condition that requires Hospitalization or general Anesthesia for dental care.

FF. Hair pieces and wigs for those who are undergoing chemotherapy.

GG. Treatment, services and supplies in connection with Morbid Obesity or disease etiology.

HH. Charges for Private Duty Nursing services of a Registered Nurse (RN) in or out of a Hospital or a Licensed Practical Nurse (LPN) in a Hospital. Private Duty Nursing services are covered only to the extent that they are Medically Necessary. Payment is not made for services which are custodial.

II. Charges for a qualified individual for routine costs of an Approved Clinical Trial when the routine costs would be a Covered Expense if provided outside of the Approved Clinical Trial. This excludes:
1. the Investigational item, device or service itself.
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

A qualified individual is a Participant who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. The referring health care provider must conclude that the Participant's involvement in the clinical trial is appropriate or the Participant must provide information establishing why participation in the clinic trial is appropriate.

JJ. Charges for treatment, services or supplies for a surrogate mother or any pregnancy for a covered Participant's service as a surrogate mother.

KK. Charges for Virtual Care.

LL. Charges for acupuncture or acupressure when administered by an MD or DO.

MM. **Preventive Care services** as outlined by Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services require non-grandfathered group health plans to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:
1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography and prevention issued in or around November 2009. For the most current listing, please visit the USPSTF website at http://www.uspreventiveservicestaskforce.org.

2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. http://www.cdc.gov/vaccines/acip/index.html
3. With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The HRSA supports the comprehensive guidelines in the *Periodicity Schedule of the Bright Futures Recommendations* for Pediatric Preventive Health Care and the *Recommended Uniform Screening Panel* of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx
4. With respect to women, evidence-informed Preventive Care and screening provided for in comprehensive guidelines supported by HRSA to the extent not already included in the current recommendations of the USPSTF. http://www.hrsa.gov/womensguidelines

Changes to the guidelines and recommendations will be adopted in compliance of the rules of the regulation. **NOTE:** Preventive Care services will be covered at 100% for non-Preferred Providers if there is no Preferred Provider who can provide a required preventive service.

Covered Expenses will be payable, as shown in the Schedule of Benefits, for the following services. Checkups or routine examinations include the office visit and related charges for:

Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked.
- Alcohol misuse screening and counseling.
- Blood pressure screening.
- Bowel preps for use in colorectal cancer screening for adults ages 50 to 75.
- Cholesterol screening for men ages 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease, for men ages 35 and older for lipid disorders and for women ages 20 and older for lipid disorders if they are at increased risk for coronary heart disease.
- Colorectal cancer screening for adults ages 50 to 75. Screenings include but are not limited to Cologuard, colonoscopy, CT colonography, flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, gFOBT, FIT, FIT-DNA, serology tests and other tests and procedures that are medically recognized and are non-Experimental/Investigational in nature. This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.
- Depression screening.
- Diabetes screening for adults ages 40 to 70 who are overweight or obese.
- Diet and physical activity counseling to prevent cardiovascular disease for adults with cardiovascular risk factors (i.e., those who are overweight or obese and have additional cardiovascular disease risk factors).
- Hepatitis B screening for adults at high risk for infection.
- Hepatitis C virus infection screening for adults at high risk for infection and one-time screening for adults born between 1945 and 1965.
- HIV screening for adults ages 18 to 65 and for older adults who are at increased risk.

- Immunization vaccines for adults – Doses, recommended ages and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster (shingles)
  - Human Papillomavirus (HPV)
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Tetanus, Diphtheria, Pertussis (whooping cough)
  - Varicella (chicken pox)
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults ages 50 to 59 who are at increased risk of cardiovascular disease.
- Lung cancer annual screening with low-dose computed tomography in adults ages 55 to 80 who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Obesity screening for all adults followed by intensive, multicomponent behavioral interventions for adults with a body mass index of 30 kg/m^2 or higher.
- Prevention of falls – Physical Therapy for community-dwelling adults ages 65 and older who are at risk for falls.
- Sexually transmitted infections – Intensive behavioral counseling for adults who are at increased risk for sexually transmitted infections.
- Skin cancer behavioral counseling for adults ages 18 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.
- Syphilis screening for adults at increased risk.
- Tobacco use screening and behavioral interventions and FDA-approved pharmacotherapy for cessation for all adult tobacco users.
- Tuberculosis screening for adults at increased risk.
- Vitamin D supplements, OTC only, to prevent falls in community-dwelling adults ages 65 and older.

Preventive Services for Women, including Pregnant Women or Women Who May Become Pregnant

- Bacteriuria urinary tract or other infection screening for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- BRCA risk assessment and counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.
- Breast cancer chemoprevention counseling and medications for women at higher risk.
- Breast cancer mammography screenings every 1 to 2 years for women ages 40 and over.
- Breast feeding support, equipment and counseling – Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. Rental or purchase of one standard electric breast pump is allowed in conjunction with each birth. A standard electric breast pump is defined as double electric pump and does not include Hospital grade pumps. Breast pumps purchased from a retail store will be paid at the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply. Purchases from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement.

Rental of a hospital grade pump is covered when Medically Necessary as a result of maternal-infant separation due to illness, prematurity or hospitalization and only for the duration of the separation. If rented, the allowed rental cost will not exceed the purchase price.

- Cervical cancer and dysplasia screening for women ages 21 to 65 with cytology (Pap smear) every 3 years or, for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
- Chlamydia and gonorrhea screening in sexually active women age 24 or younger and in older women who are at increased risk for infection.
- Contraception and contraceptive counseling – All food and drug administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed.
- Domestic/intimate partner violence – Annual screening and counseling for interpersonal and domestic violence for women of childbearing age.
- Folic acid daily supplements containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women who may become pregnant.
- Gestational diabetes screening in pregnant women after 24 weeks of gestation and at the first prenatal visit for pregnant women who are high risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Human papillomavirus (HPV) DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
- Osteoporosis screening for women ages 65 and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors
- Preeclampsia prevention low-dose aspirin for pregnant women after 12 weeks of gestation who are at high risk.
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care. Also repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative.
- Sexually transmitted infections counseling for sexually active women.
- Syphilis and HIV screening for all pregnant women.
- Tobacco use screening and behavioral interventions for cessation for all pregnant women who use tobacco.
- Well-woman visits – Visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Frequency: Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

Preventive Services for Children

- Alcohol and drug use assessments.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments.
- Bilirubin screening for all newborns.
- Blood pressure screening.
- Congenital hypothyroidism screening for all newborns.
- Critical congenital heart disease screening for all newborns.
- Dental caries prevention up to age 5 – Limited to fluoride varnish to primary teeth and oral fluoride. Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
- Depression screening for children ages 12 years and older.

- Developmental screening for children under age 3 and surveillance throughout childhood.
- Dyslipidemia screening once between ages 9 and 11 years and once between ages 17 and 21 years.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening up to age 21 as indicated by the American Academy of Pediatrics.
- Height, weight and Body Mass Index measurements.
- Hematocrit or hemoglobin screening.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for children at high risk for infection.
- HIV screening for children ages 15 to 18 years and for younger children who are at increased risk.
- Immunization vaccines for children from birth to age 18 – Doses, recommended ages and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis (whooping cough)
  - Haemophilus influenzae type b (Hib disease)
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (HPV)
  - Inactivated Poliovirus
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Rotavirus
  - Varicella (chicken pox)
- Lead screening.
- Medical history.
- Obesity screening for children ages 6 years and older followed by comprehensive, intensive behavioral interventions to promote improvement in weight status.
- Oral health risk assessment.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted infections – Intensive behavioral counseling and screening for adolescents.
- Skin cancer behavioral counseling for children who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.
- Syphilis screening for children at increased risk.
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- Tuberculosis testing.
- Vision acuity screening for all children.

NN. The Plan shall cover the following additional **Preventive Care services as outlined in the schedule of benefits:**

- Immunizations for the purpose of travel.

OO. Charges for diagnostic testing, intensive and non-intensive level services for autism disorder, Asperger's syndrome and any pervasive development disorder not otherwise specified. This coverage will be provided in accordance with all the terms and conditions of Wis. Stat. 632.895(12m), including the definition of a licensed provider, covered items, limitations, exclusions, applicable dollar limits, etc.

PP. Sales tax, if any, on Medically Necessary services.

CHARGES NOT COVERED

Charges not covered are those charges for:

1. any treatment of teeth or nerves connected to teeth except as specifically provided in the Plan.

2. vision exams, eye refraction or any procedure to correct a refractive error, eyeglasses, contact lenses (including for the treatment of keratoconus), orthoptic training, hearing aids, cochlear implants, except as specifically provided in the Plan, dental prosthetic appliances or such similar aids devices, except as required due to an accidental Injury. Also the exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed.

3. services and supplies in connection with Injury caused by war whether declared or not or by international armed conflict.

4. services of any person who is a member of your immediate family or who resides in your home.

5. services of a Social Worker including a psychological or psychiatric Social Worker, other than for which there is a benefit available under Home Health Care Services, Hospice Care Services or the Outpatient treatment of a Mental and Nervous condition or alcohol/drug dependency.

6. expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

7. charges which you would not be required to pay if there were no coverage.

8. services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

9. your dependent for any medical expense for which the dependent is entitled to benefits as an Employee or former Employee of the policyholder.

10. confinement in a place which is primarily a school, a place of rest, a place for the aged or a nursing home.

11. Hospice care services by volunteers or individuals who do not regularly charge for their services. Hospice care services by a licensed pastoral counselor to a member of his or her congregation. These are the services in the course of duties to which he or she is called as a pastor or minister.

12. Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
    a. care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment;
    b. care that can safely and adequately be provided by persons who do not have the technical skills of a covered Health Care Professional.

Care that meets one of the conditions above is custodial regardless of any of the following:

a. who recommends, provides or directs the care;
b. where the care is provided;
c. whether or not the patient can be or is being trained to care for himself or herself.

13. cosmetic, plastic, reconstructive or restorative surgery unless such Covered Expenses are Incurred for repair of a disfigurement caused from any of the following:
    a. an accidental Injury;
    b. a Birth Defect;
    c. as the result of a covered surgical procedure.

14. Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or if filed, that a conviction result. Proof beyond a Reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

15. any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit: ***If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.***

16. charges made with respect to one person but which are Incurred due to the Injury or Illness of a different person no matter which person incurs the expense.

17. confinement, treatment, services or supplies given for or related to any of the following:
    a. in-vitro fertilization;
    b. embryo transfer procedures;
    c. artificial insemination.

18. sex-change surgery.

19. reversal of sterilization.

20. chelation therapy, except to treat heavy metal poisoning.

21. Speech Therapy, except as specifically provided in the Plan.

22. acupuncture or acupressure unless administered by an MD or DO.

23. services that are Experimental or Investigational.

24. any loss directly or indirectly caused by or contributed to or arising from:
    a. ionizing radiation, pollution or contamination by radioactivity from nuclear waste from the combustion of nuclear fuel; and

b. the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof, as covered under the U.S. Atomic Energy Pool.

25. services or supplies which constitute personal comfort or beautification items, television or telephone use, physical fitness programs or equipment or exercise therapy.

26. initial Friday, Saturday and Sunday Room and Board charges Incurred for Hospital confinement which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions or scheduled surgery within the 24-hour period immediately following Hospital admission.

27 Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a documented medical condition such as depression or if the Participant is a victim of domestic violence and the benefits for such Injuries are normally covered under the Plan.

28. expenses in connection with the treatment of developmental delays, including, but not limited to Speech Therapy, Occupational Therapy and Physical Therapy will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).

29. recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships will not be considered eligible. This exclusion will not apply to diabetic self-management education programs or expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).

30. treatment, services and supplies in connection with obesity, weight reduction or dietetic control, except for Morbid Obesity and disease etiology.

31. treatment, service or supplies due to complications of a non-Covered Expense.

32. routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak unstable, flat, strained or unbalanced feet, unless an open-cutting operation is performed; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails unless the treatment is Medically Necessary. Medically Necessary pedicures provided by a qualified Health Care Professional are considered a Covered Expense.

33. wigs, artificial hair pieces, artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, unless specifically provided in the Plan.

34. except as specified herein, charges for services provided to a covered Participant for an elective abortion; however, complications from such procedure shall be a Covered Expense.

35. services that are not Medically Necessary.

36. services to a Plan Participant, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

37. services, supplies, care or treatment to a Participant for Injury or Illness resulting from that Participant's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

38. services that are not "Reasonable," or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and that are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

39. expenses actually Incurred by other persons.

40. Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

41. that are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies or services for which a person, company or any other entity except the Participant or this benefit plan, **may be liable** for necessitating the fees, care, supplies or services.

42. that are not accepted as standard practice by the AMA, ADA or the Food and Drug Administration.

43. that are not actually rendered.

44. that are not specifically covered under this Plan.

45. other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

46. to the extent that payment under this Plan is prohibited by law.

47. required as a result of unreasonable provider error.

48. services for an Injury or Illness not payable by virtue of the Plan's subrogation reimbursement and/or third party responsibility provisions.

49. incremental nursing charges which are in addition to the Hospital's standard charge for Room and Board. This exclusion will not apply in the event that Room and Board charges are appropriately modified when billed with documented extraordinary or non-routine nursing care services, also known as incremental nursing charges.

50. pool therapy, aquatic therapy and hydrotherapy, except as specifically provided in the Plan. Charges for aquatic exercise programs or separate charges for the use of a pool will not be considered eligible.

51. exams directed or requested by a third party or a court of law, including but not limited to routine physical exams for licensure, occupation, sports participants, employment or the purchase of insurance. This does not include court-ordered exams for mental-health services.

GENERAL EXCLUSIONS AND LIMITATIONS

Excluded from coverage are any charges Incurred as a result of:

A. travel or flight in (including boarding or alighting therefrom and learning to operate) any type of aircraft or any other aerial device while such aircraft or device is:
   1. being used for a test purpose;
   2. being operated by or for or under the command of the military authority (other than a transport type aircraft operated by the Military Air Transport Service (MATS) of the United States or like air service of some other country).

C. charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

D. this Plan will not pay for any charge which has been refused by an Other Plan covering the covered Participant as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

E. charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.

F. charges for Illnesses or Injuries suffered by a covered Participant due to the action or inaction of any party if the covered Participant fails to provide information as specified in Subrogation.

G. claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.

H. if the primary plan has a restricted list of healthcare providers and the covered Participant chose not to use a provider from the primary plan's restricted list, this Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

I. charges for any care, supplies, treatment and/or service that are required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

The Plan is administered by the Plan Administrator within the applicable law and jurisdiction and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any Claim for Benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a Claim for Benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by applicable law;
10. To establish and communicate procedures to determine whether a medical Child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by applicable law. In the event, that the Plan Sponsor is a different type of entity, then such amendment suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of the date established by the Plan Sponsor.

DEFINITIONS

For the purpose of the coverage provided under this policy,

ACCIDENT means a bodily Injury sustained independently of all other causes, that is sudden, direct and unforeseen and is exact as to time and place.

ACTIVE DUTY means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military services, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

ADA means the American Dental Association.

ADMINISTRATIVE PERIOD means a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

ADVERSE BENEFIT DETERMINATION shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits;
4. A rescission of coverage, even if the rescission does not impact a current claim for benefits;
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

ALLOWABLE EXPENSES means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

ALTERNATE RECIPIENT means any Child of a Participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such Participant.

AMBULATORY SURGICAL CENTER means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures.

The center must be licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

ANESTHESIA
Local – means the condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

General – means the condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

ANESTHETIC means a drug that produces loss of feeling or sensation either generally or locally.

APPROVED CLINICAL TRIAL means a phase I, II, III or IV trial that is federally funded by specified agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's network area unless out-of-network benefits are otherwise provided under the plan.

ASSIGNMENT OF BENEFITS means an arrangement whereby the Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits previously issued to a provider at its discretion and continue to treat the Participant as the sole beneficiary.

AUTHORIZED REPRESENTATIVE means a Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

AVERAGE SEMI-PRIVATE CHARGE means the average of such charges where the Hospital has more than one established level of such charges.

BIRTH CENTER means a specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

1. it is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located;
2. it meets all of the following requirements:
   a. it is operated and equipped in accordance with any applicable state law;
   b. it is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
   c. it has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation and blood expanders;
   d. it is operated under the full-time supervision of a licensed doctor of medicine (M.D.) or Registered Nurse;
   e. it maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications;
   f. it maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, laboratory or diagnostic tests and a postpartum summary.

BIRTH DEFECT for the purpose of administration of this Plan means a structural malformation of a body part, recognizable at birth, which is significant enough to be perceived as a problem.

CALENDAR YEAR means a period from January 1 through the following December 31, both dates inclusive.

CHILD means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

CLAIM FOR BENEFITS means a request for a plan benefit or benefits made by a Claimant in accordance with a Plan's Reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for preauthorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

CLAIMANT means a person requesting benefits under the Plan. A Claimant may or may not be a covered person under the Plan.

CLEAN CLAIM means one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A Claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

CLOSE RELATIVE means the Employee, Employee's Spouse and the children, brothers, sisters and parents of either the Employee or the Employee's Spouse.

COMMITTEE means the Health Care Committee of the School District, as appointed by the Board from time to time.

CONCURRENT CARE means ongoing care or course of treatment.

CONTINGENCY OPERATION means designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operation, or hostilities against an enemy of the United States or against an opposing military force.

COVERED EXPENSE means a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document.

COVERED SERVICEMEMBER means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in Outpatient status, or is otherwise on the temporary Disability retired list, for a serious Injury or Illness.

Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious Injury or Illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation or therapy.

CUSTODIAL CARE means care which:

1. is provided mainly to maintain the covered individual; or
2. is designed in order to help the covered individual meet his activities of daily living;
3. is not provided mainly as a type of therapy in the treatment of an Illness or Injury;
   a. help in walking; bathing; dressing or feeding;
   b. preparing special diets;
   c. supervising and giving of medications that do not require constant attention of trained medical personnel.

DISABILITY or TOTALLY DISABLED means:

1. that an Employee is prevented from engaging in any and every business or occupation and performing any and all work for compensation or profit;
2. that any other covered individual is prevented from engaging in all normal pursuits of other people of the same age and sex and in good health because of Injury or Illness.

DURABLE MEDICAL EQUIPMENT means equipment which is:

1. able to withstand repeated use;
2. primarily and customarily used to treat an Illness or Injury;
3. not generally useful for a person in the absence of Illness or Injury.

The equipment must be prescribed by a Physician as needed in the treatment of the Illness or Injury and will be provided on a rental basis for the period of treatment unless the cost for rental for such a period is in excess of the purchase price. Purchase of the equipment will then be considered by the Plan Administrator.

Durable Medical Equipment does not include:

1. items and self-help devices not chiefly medical in nature;
2. items for comfort and convenience;
3. Physician's equipment;
4. disposable supplies unless provided in connection with direct Physician care or covered home care; or
5. exercise and hygienic equipment.

EFFECTIVE DATE means the first day that benefits under this Plan would be in effect, after satisfaction of the Waiting Period, if applicable, and any other provisions or limitations contained herein.

EMBEDDED means an Embedded deductible wherein the individual deductible is included within the family deductible. Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. For example, if there is a family deductible of $3,000 with an individual Embedded deductible of $1,500, then when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

EMERGENCY means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867 (e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

EMPLOYEE means an individual: (1) whose relationship to an Employer is within the meaning of "Employee" for federal tax withholding purposes; (2) who is authorized to work in the United States; and (3) who is not a leased Employee, treated as an independent contractor by an Employer, or otherwise compensated by an Employer outside of its normal payroll. A former Employee may be treated as an Employee hereunder during the time that such individual is a COBRA continuee.

EMPLOYER means the company and any entity that is affiliated with the company within the meaning of Section 414(b), (c) or (m) of the Code, that adopts this Plan for the benefit of its Employees, whose participation in the Plan is approved by the President (or any other duly authorized officer) of the company. An Employer may withdraw from the Plan by delivering to the applicable Plan Supervisor written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

ESSENTIAL HEALTH BENEFITS means under section 1302(b) of the Affordable Care Act (ACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPERIMENTAL or INVESTIGATIONAL means services or treatment that are not widely used or accepted by most or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care procedures, treatments or courses of treatment which:

1. do not constitute accepted medical practice under the standards of the case and by the standards of a Reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials under study to determine its:
    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. only published reports and articles in the authoritative medical and scientific literature;
2. the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

FAMILY AND MEDICAL LEAVE ACT OF 1993 – All previous provisions including coverage under this Plan, effective date of coverage and termination of coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA), as amended. To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA means the Family and Medical Leave Act of 1993, as amended.

FMLA LEAVE means a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

FULL-TIME STUDENT means a participating dependent Child who is enrolled in and regularly attending an accredited college, university or vocational or technical school. For the purpose of this definition, "full-time" means a minimum of twelve semester or quarter hours, unless the school's definition of full-time attendance is less. For vocational and technical school, the definition of full-time attendance must be provided by the school itself.

GENETIC INFORMATION includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about any disease, disorder, or condition of an individual's family members (i.e., an individual's family medical history).

GINA means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, insurers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

HEALTH CARE PROFESSIONAL means a Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE AGENCY means an agency or organization which provides a program of home health care and which fully meets one of the following three tests:

1. it is approved under Medicare;
2. it is established and operated in accordance with the applicable licensing and other laws;
3. it meets all of the following tests:
    a. it has the primary purpose of providing a home health care delivery system bringing supportive services to the home;
    b. it has a full-time administrator;
    c. it maintains written records of services provided to the patient;
    d. its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available;
    e. its Employees are bonded and it provides malpractice insurance.

HOSPICE means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL means an institution accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including surgical facilities for all institutions other than those specializing in the care and treatment of mentally ill patients, provided such institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons on an Inpatient basis with 24-hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed, if it is not a State tax supported institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare shall not be deemed to be Hospitals for this Plan's purposes.

HOUR OF SERVICE means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and each hour for which an Employee is paid, or entitled to payment by the Employer, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

ILLNESS means a covered bodily or Mental infirmity or pregnancy.

INCAPACITATED PERSON means an individual who, for reasons other than being a minor, is impaired to the extent of lacking sufficient understanding or capacity to make or communicate responsible personal decisions, and who has demonstrated deficits in behavior which evidence an inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological assistance.

INCURRED means that a Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

INJURY means a covered accidental bodily Injury caused by an external force.

INPATIENT means the classification of a covered person when that person is admitted to a Hospital, Hospice, Specialized Treatment Facility or Skilled Nursing Facility for treatment and charges are made for Room and Board to the covered person as a result of such treatment.

INTENSIVE CARE or **SPECIAL CARE UNIT** means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending Physician which provides Room and Board, trained and qualified personnel whose duties are primarily confined to such unit and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

LEGALLY EMPLOYED means the Employee has presented valid documentation to the Employer showing evidence of his/her authorization to work in the United States.

LICENSED PRACTICAL NURSE (L.P.N.) means an individual who has received specialized nursing training, performs practical nursing services and is licensed by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED VOCATIONAL NURSE (L.V.N.) means an individual who has received specialized nursing training and is authorized to use the designation "L.V.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

LIFETIME when used in reference to benefit maximums and limitations means "while covered under this Plan." Under no circumstances does Lifetime mean "during the Lifetime of the Covered Person."

MAXIMUM AMOUNT and/or MAXIMUM ALLOWABLE CHARGE will be a negotiated rate, if one exists. In the absence of a negotiated rate, the Maximum Amount(s) will be calculated by the Plan Administrator taking into account any or all of the following:

1. the Usual and Customary amount;
2. the allowable charge specified under the terms of the Plan;
3. the Reasonable charge specified under the terms of the Plan; or
4. the actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

MEASUREMENT PERIOD means a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

- Initial Measurement Period – for newly hired Variable Hour Employees, this Measurement Period will start from the date of hire and end after 12 consecutive months of service.
- Standard Measurement Period – for Ongoing Employees, this Measurement Period will start on January 1 each year and will last for 12 consecutive months.

MEDICAL CARE NECESSITY/MEDICALLY NECESSARY/MEDICAL NECESSITY means health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be not more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Illness or Injury without adversely affecting the Plan Participant's medical condition.

1. it must not be maintenance therapy or maintenance treatment.
2. its purpose must be to restore health.
3. it must not be primarily custodial in nature.
4. it must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
5. the Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

MEDICAL RECORD REVIEW means the process by which the Plan based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

MENTAL OR NERVOUS DISORDER means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

MINOR EMERGENCY MEDICAL CLINIC means a free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a covered person. A board certified Physician, a Registered Nurse and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of the Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way part of a regular Hospital shall be excluded from the terms of this definition.

MORBID OBESITY means either:

1. the Participant weighs more than 100 pounds over standard weight for height, sex and age; or
2. the Participant weighs more than 2 times the standard weight for height, sex and age; whichever is less. For a Participant who is less than 19 years of age, Morbid Obesity means that the Participant's weight is 50% greater than ideal body weight.

NEW EMPLOYEE means an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

NEXT OF KIN means the nearest blood relative of an individual.

NON-VARIABLE HOUR EMPLOYEE means an Employee reasonably expected at the time of hire to work six (6) hours per day / thirty (30) hours per week or 130 hours per month during the school year.

NURSE-MIDWIFE means a person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

1. a person licensed by a board of nursing as a Registered Nurse;
2. a person who has completed a program approved by the state for the preparation of Nurse-Midwives.

NURSE PRACTITIONER means an individual who is licensed as a Registered Nurse under Chapter 441, Wisconsin Statutes or the laws of another state and who satisfies any of the following:

1. is certified as a primary care Nurse Practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;
2. holds a master's degree in nursing from an accredited school of nursing;
3. prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares Registered Nurses to perform an expanded role in the delivery of primary care, included at least four months of classroom instruction and a component of supervised clinical practice and awards a degree, diploma or certificate to individuals who successfully complete the program; or
4. has successfully completed a formal education program that is intended to prepare Registered Nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (3) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

OCCUPATIONAL THERAPY means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to use his fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy which is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered covered services under this Plan.

ONGOING EMPLOYEE means an Employee who has been employed by the Employer for at least one complete Measurement Period.

OTHER PLAN shall include, but is not limited to:

1. any primary payer besides the Plan;
2. any other group health plan;
3. any other coverage or policy covering the Participant;
4. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. any policy of insurance from any insurance company or guarantor of a responsible party;
6. any policy of insurance from any insurance company or guarantor of a third party;
7. worker's compensation or other liability insurance company; or
8. any other source, including but not limited to crime victim restitution funds, and medical Disability or other benefit payments, and school insurance coverage.

OTHER SERVICES AND SUPPLIES means services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

OUTPATIENT means the classification of a covered person when that covered person receives medical care, treatment, services or supplies at a clinic, a Physician's office, a Hospital if not a registered bed patient at that Hospital or Outpatient Specialized Treatment Facility.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY means an institution which provides a program for diagnosis, evaluation and effective treatment of alcoholism; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

PARTICIPANT means any Employee or dependent who has been enrolled and approved for coverage under the Plan.

PHYSICAL THERAPY means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint) the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

PHYSICIAN means a legally qualified:
1. Doctor of Medicine (M.D.);
2. Doctor of Chiropody (D.P.M.; D.S.C.);
3. Doctor of Chiropractic (D.C.);
4. Doctor of Dental Surgery (D.D.S.);
5. Doctor of Medical Dentistry (D.M.D.);
6. Doctor of Osteopathy (D.O.);
7. Doctor of Podiatry (D.P.M.).

POST-SERVICE CLAIM means any claim that is not a Pre-Service Claim.

PRE-ADMISSION TESTS means tests performed on you or your dependent in a Hospital before confinement as a resident Inpatient provided they meet all of the following requirements:
1. the tests are related to the performance of scheduled surgery;
2. the tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital;
3. you or your dependent are subsequently admitted to the Hospital or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your dependent's condition which precludes the surgery.

PRE-SERVICE CLAIM means any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

PREFERRED PROVIDER means a Physician, Hospital or other provider that is currently a participating member of a network of providers who have agreed with the Plan to provide services to eligible Participants at a negotiated rate. For prescription drugs available through the prescription drug and/or specialty drug program (as applicable), Preferred Provider means the prescription drug card program or specialty drug program and does not include any other network of providers with which the Plan contracts.

PREVENTIVE CARE means certain Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/coverage/preventive-care-benefits. For more information, Participants may contact the Plan Administrator / Employer.

PRIOR TO EFFECTIVE DATE or AFTER TERMINATION DATE means dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred prior to the Effective Date of coverage under the Plan or after coverage is terminated.

PRIVATE DUTY NURSING means continuous bedside nursing service, rendered by one nurse to one patient, either in a Hospital, Skilled Nursing Facility, Hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an Inpatient setting.

PSYCHIATRIC (MENTAL/NERVOUS) TREATMENT FACILITY means an administratively distinct governmental, public, private or independent unit or part of such unit that provides psychiatric services and care; such facility is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician and meets appropriate licensing standards.

PSYCHOLOGIST means such person:

1. who is so licensed; or
2. who is so certified; or
3. who is listed in the National Register of Health Service Providers; or
4. who is a diplomat in clinical psychology through the American Board of Professional Psychologists.

REASONABLE and/or REASONABLENESS means in the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organization; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients are not Reasonable.

The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

REGISTERED NURSE (R.N.) means an individual who has received specialized nursing training and is authorized to use the designation "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

REHABILITATION FACILITY means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services or an institution which primarily provides treatment of Mental Disorders, Chemical Dependency or tuberculosis except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

RETIREE means a covered Employee of the company who has met the criteria established in the Administrator's Master Agreement, Supervisor's Master Agreement or the CFFT Master Agreement. A Retiree is considered an Employee for medical coverage under this Plan.

ROOM AND BOARD means room, board, general duty nursing, intensive nursing care by whatever name called and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an Intensive Care Unit by whatever name called.

SCHOOL DISTRICT means the Chippewa Falls Area Unified School District, a Wisconsin corporation, and any successor thereto (whether by merger, consolidation, sale of assets, or otherwise) which elects in writing to adopt this Plan.

SKILLED NURSING FACILITY means if the facility is approved by Medicare as a Skilled Nursing Facility then it is covered by the Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

1. it is operated under the applicable licensing and other laws;
2. it is under the supervision of a licensed Physician or Registered Nurse (R.N.) who is devoting full-time to supervision;
3. it is regularly engaged in providing Room and Board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness;
4. it maintains a daily medical record of each patient who is under the care of a duly licensed Physician;
5. it is authorized to administer medication to patients on the order of a duly licensed Physician;
6. it is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home or a home for alcoholics, drug addicts or the Mentally ill.

The term shall also apply to expenses Incurred in an institution referring to itself as a Convalescent Nursing Home, Extended Care Facility or any such other similar nomenclature.

SOCIAL WORKER means only a person who specializes in clinical social work and is licensed or certified as a Social Worker by the appropriate authority.

SPEECH THERAPIST means only a person who is licensed as a Speech Therapist. A Speech Therapist must act within the scope of the practice.

SPEECH THERAPY/PATHOLOGY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing, etc. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

SPOUSE means an Employee's lawfully married husband or wife (of the same or opposite sex) under a legal marriage (who is neither divorced nor legally separated).

STABILITY PERIOD means a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period and is used by the Employer as part of the look-back measurement method. The Stability Period is a 12-month period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

SUBSTANCE ABUSE and/or SUBSTANCE USE DISORDER means any use of alcohol, any drug (whether obtained legally or illegally), and narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

1. a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
    a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    b. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. craving or strong desire or urge to use a substance; or
    d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights);

SUBSTANCE ABUSE TREATMENT FACILITY means an institution which provides a program for diagnosis, evaluation and effective treatment of alcoholism and/or drug use or abuse; provides detoxification services, provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician and meets licensing standards.

UNIFORMED SERVCIES shall include the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or Emergency.

URGENT CARE CLAIM means any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

USERRA means the Uniformed Services Employment and Reemployment Rights Act under which Employees will be eligible for coverage on the date they return to work, provided the Employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active Employees and dependents. Eligibility Waiting Periods will be imposed only to the extent they are applicable prior to the period of uniformed services.

USUAL AND CUSTOMARY means Covered Expenses which are identified by the Plan Administrator taking into consideration any or all of the following: the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment supplies of similar standing which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The Term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to the Plan Participant by a Provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

VARIABLE HOUR EMPLOYEE means an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

VIRTUAL CARE means professional evaluation and medical management services provided to patients through live, interactive audio and visual transmissions. Virtual Care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which Physicians respond with substantive medical advice. Virtual Care does not include services that do not involve direct in person patient contact such as telephone calls or emails.

WAITING PERIOD means the time between the first day of employment and the first day of coverage under the Plan.

WELL BABY CARE / WELL CHILD CARE means pediatric preventive services appropriate to the age of the Child as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan. Coordination does apply to prescription drug benefits available under a prescription drug card allowing your Prescription Benefit Manager (PBM) to determine eligible benefits when this Plan is considered secondary.

Excess Insurance

If at the time of Injury, Illness, disease or Disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. any primary payer besides the Plan;
2. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsurance motorist coverage;
3. any policy of insurance from any insurance company or guarantor of a third party;
4. worker's compensation or other liability insurance company; or
5. any other source, including but not limited to crime victim restitution funds, any medical, Disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses

"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Claim Determination Period

"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits:

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules to the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefits determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year falls earlier in the year) will be primary, except:
    a. When the parents were never married, are separated or are divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the stepparent, and the benefits of a plan which covers that Child as a dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a dependent Child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payment which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

PROVISION FOR COORDINATION OF BENEFITS WITH MEDICARE

Definitions

1. "Medicare" means that portion of Title 18 of the United States Social Security Act of 1965, as then constituted or as amended in the future.

2. "Fully Covered Person" means any person who is eligible for Medicare Coverage.

3. "Full Medicare Coverage" means coverage for all of the benefits provided under Medicare including Medicare Part D, and any benefits provided on an optional basis. (Medicare Part D election is only applicable to Employees and dependents with a retirement date on or after June 1, 2014.)

Effects on Benefits

The benefits payable under this Plan for expenses Incurred (as determined by the Covered Expenses section of this Plan) by a Fully Covered Person shall be reduced by the amount such Fully Covered Person is eligible for benefits under Full Medicare Coverage. Any benefits received from Full Medicare Coverage not covered by this Plan shall not reduce benefits payable under this Plan.

Except that:

For working Employees age 65 and older who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage may provide supplemental benefits for those expenses not paid by this Plan. If the working Employee's Spouse is also enrolled in this Plan, this provision would apply to the Spouse during the period of time both the Employee and the Spouse are age 65 and older. If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997) and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law. This provision intends to comply with the TEFRA Act of 1982.

HEALTH CLAIM PROVISIONS

Health Claims

All claims and questions regarding health claims should be directed to Benefit Plan Administrators (the Claims Administrator). The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to Benefit Plan Administrators provided, however, that Benefit Plan Administrators is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual Claim for Benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-Urgent), Concurrent Care and Post-service.

- Pre-Service Claims. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-Service Claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Post-Service Claims. A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Post-service health claims, which must be Clean Claims, must be filed with Benefit Plan Administrators within 365 days of the date charges for the services were Incurred. Post-service Medicare Part D prescription claims must be filed with Benefit Plan Administrators within three years of the date the prescription was filled. Benefits are based upon the Plan's provisions at the time the charges were Incurred or the prescription filled. **Claims filed later than the indicated dates shall be denied.**

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Benefit Plan Administrators in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. Benefit Plan Administrators will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by Benefit Plan Administrators within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-Service Urgent Care Claims:
  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - The Participant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:

    The Plan's receipt of the specified information; or

    The end of the period afforded the Participant to provide the information.
  - If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.
- Pre-Service Non-Urgent Care Claims:
  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a Reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

  - Request by Participant Involving Non-Urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

  - Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

Notification to Participant	30 days
Notification of Adverse Benefit Determination on appeal	30 days

- Post-Service Claims:

  - If the Participant has provided all of the information needed to process the claim, in a Reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-Service Urgent Care Claims. No extensions are available in connection with Pre-Service Urgent Care Claims.

- Extensions – Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, Reasonable access to, and copies of, all documents, records and other information relevant to the Participant's Claim for Benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a Claim for Benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a Reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) Reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Benefit Plan Administrators; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a Reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For Pre-Service Urgent Care Claims, if the Participant chooses to orally appeal, the Participant may telephone:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

It shall be the responsibility of the Participant to submit proof that the Claim for Benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Participant;
- The Employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the Claim for Benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-Service Non-Urgent Care Claims: Within a Reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-Service Claims: Within a Reasonable period of time, but not later than 60 days after receipt of the appeal. **NOTE:** This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, Reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's Claim for Benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

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

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

Two Levels of Appeal
This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process in accordance with the current Affordable Care Act regulations, applies only to:
   (a) Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph of this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The Claimant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
   (b) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative
A Participant is permitted to appoint an Authorized Representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Participant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Benefit Plan Administrators. However, in connection with a claim involving Urgent Care, the Plan will permit a Health Care Professional with knowledge of the Participant's medical condition to act as the Participant's Authorized Representative without completion of this form. In the event a Participant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the Participant unless the Participant directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Illness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Illness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. This prohibition applies to providers as well.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, if bound by the rules and provisions set forth within the terms of this document.

Non-U.S. Providers
Medical expense for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Participant is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of this Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against the Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deductible may be made against any Claim for Benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Plan Participant for any outstanding amount(s).

Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program, and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Claims Audit
In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a compete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge in accord with the terms of this Plan Document.

Limitation of Action
A Participant cannot bring any legal action against the Plan to recover reimbursement until 90 days after the Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Participant's claim have been completed. If the Participant wants to bring a legal action against the Plan, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan.

A Participant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

AMENDMENT AND TERMINATION

Right to Amend and Terminate

The Company shall have the right at any time to amend or modify this Plan, retroactively or otherwise, or to terminate or partially terminate this Plan; provided that no such amendment or termination shall:

1. cause or permit the benefit funds to be used for any purpose other than the payment of benefits to Participants or Reasonable administrative expenses;
2. in any manner impair the right of a Participant who has Incurred Covered Charges or is entitled to benefits under this Plan upon the adoption of such amendment to receive benefit payments provided for under this Plan prior to such amendment.

GENERAL PROVISIONS

In General. Any and all rights or benefits accruing to any person under this Plan shall be subject to all terms and conditions of this Plan. The adoption and maintenance of this Plan shall not constitute a contract between the Company and any Participant or be consideration for, or an inducement or condition of, employment of an Employee. Neither participation nor anything contained in this Plan shall give any Employee the right to be retained in the Employ of the Company, nor shall it interfere with the right of the Company to discharge any Employee at any time.

Filing of Information. Each Covered Employee, Covered Dependent or other interested person shall file with the Plan Administrator such pertinent information concerning himself as the Plan Administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan Administrator may specify or provide, and such person shall not have rights or be entitled to any benefits or further benefits hereunder unless such information is filed by him or on his behalf.

Payments to Others than Participants. If the Plan Administrator shall find that any person to whom any benefits are payable under this Plan is unable to care for his affairs, is a minor or has died, then any payment due to him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to the Spouse, a Child, a relative, an institution maintaining or having custody of such person or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment or the Plan Administrator may in its discretion hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this Plan.

Cancellation of Benefits. If the Plan Administrator is unable to ascertain the whereabouts of any person to whom benefits are payable under the Plan, and if, after one year from the date such payment is due, a notice of such payment due is mailed to the last known address of such person as shown on the records of the Plan Administrator, and within three months after such mailing such person has not filed with the Plan Administrator written claim therefore, the Plan Administrator may direct that such payment be cancelled and forfeited and, upon such cancellation the Plan shall have no further liability therefore.

Clerical Error. Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws. This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order of judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of any other applicable law.

Headings. The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Fraud. Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration, that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire family unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

No Waiver of Estoppel. No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver of estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than specifically waived.

Participants' Personally Identifiable Information. "Participants' Information" means medical records, other medical information, social security numbers and all other personally identifiable information. The Third Party Administrator (TPA) shall keep Participants' Information in confidence and shall not release or disclose such information to any person or organization unless (i) authorized to do so by the Member or the Employer or (ii) required by law. TPA shall be held liable for any breach of confidentiality by TPA of such Participants' Information, except that the Employer shall fully protect, indemnify, defend and hold harmless TPA from and against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation that may be asserted against or Incurred by TPA resulting from or arising out of compliance by TPA with requests by the Employer to release or disclose Participants' Information.

Indemnification.

1. TPA shall, to the extent possible, advise Employer of any legal actions against it or Employer which involve the Plan or the obligations of Employer or TPA under the Plan or this Agreement. Employer shall undertake the defense of such action (including the selection of counsel for Employer and TPA acceptable to Employer) and be responsible for the costs of defense; provided, however, that Employer shall not be responsible for defense costs for actions for which TPA is required to indemnify Employer (see Item 2 below). In addition, TPA shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of TPA. It is further agreed that TPA (provided no conflicts of interest exist) shall fully cooperate with Employer in Employer's defense of any action arising out of matters related to the Plan or this Agreement.

2. In performing its obligations under this Agreement, TPA shall use Reasonable diligence and that degree of skill and judgment possessed by one experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan. TPA shall indemnify, defend and hold harmless Employer and the Plan, and their respective directors, shareholders, and agents (collectively, "Employer Group"), from and against any fine, penalty, loss, damage, Injury, claim, cost expense (including, without limitation, Reasonable attorneys' fees and other Reasonable costs and expenses incident to any suit, action, investigation, claim or proceeding) or other liability (collectively, "Liabilities") that may be asserted against or Incurred by Employer Group and that arise out of any act or omission of TPA, or its employees, agents or subcontractors ("Claims Administrator Personnel"), in connection with the performance of TPA's obligations hereunder, where such act or omission constitutes: (a) the failure of TPA to perform its obligations under the Agreement in accordance with the standard set for the above; (b) breach of fiduciary duty by TPA; or (c) the failure to apply, or negligent application of, established oversight, monitoring, or credentialing standards to any members of the health care provider panel of any managed health care organization with whom TPA or Plan, directly or indirectly through one or more levels of contracting relationships; *provided, however,* that the foregoing indemnity shall not apply to (i) Liabilities resulting from the negligence or willful misconduct of Employer, or its employees, agents or subcontractors other than TPA, or (ii) the portion of any Liabilities represented by an amount or amounts payable to a Plan pursuant to the terms of a Plan (which amounts shall be discharged by TPA by making such payment or payments from assets of such Plan).

3. TPA does not insure or underwrite the liability of Employer under the Plan. Employer retains the ultimate responsibility for claims under the Plans and all expenses incident to the Plans, except as specifically undertaken in this Agreement by TPA. Employer agrees to defend, indemnify, and hold harmless TPA and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation that may be asserted against or Incurred by TPA resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against TPA in connection with the design or of the Plans or its provision of services hereunder unless such liability is attributable to an action for which TPA is required to indemnify Employer (pursuant to Item 2 above).

Right of Recovery. In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative; any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount; and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements. All statements made by the company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors. To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, or his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Binding Arbitration. ***NOTE:*** *The Employee is enrolled in a plan provided by the Employer that is subject to ERISA; any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an adverse benefit decision, this binding arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this binding arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this binding arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds. In the event a benefits check issued by the Claims Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Claims Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA, and any other applicable State law(s).

SUBROGATION/REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or Disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance and/or guarantor(s) of a third party (collectively "coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

3. In the event a Participant(s) settles, recovers or is reimbursed by any coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:
   a. The responsible party, its insurer or any other source on behalf of that party.
   b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
   c. Any policy of insurance from any insurance company or guarantor of a third party.
   d. Workers' compensation or other liability insurance company.
   e. Any other source, including but not limited to crime victim restitution funds; any medical, Disability or other benefit payments; and school insurance coverage.

   The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, Disability or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

4. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

5. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

6. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or Disability.

Participant is a Trustee over Plan Assets

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Participant understands that he/she is required to:
   a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release or receipt of applicable funds;
   b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
   c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
   d. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Participant, beneficiary or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section, will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, disease or Disability there is available, or potentially available, any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds; any medical, Disability or other benefit payments; and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s) and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Illness, disease, Disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or coverage.
    h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Privacy Officer as outlined in the Health Insurance Portability and Accountability (HIPAA) section.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a Reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take Reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose Genetic Information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Train Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer:
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals identified above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose Reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and
    d. a person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a Reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all Reasonable requests;
3. The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy his/her PHI, or to have a copy of his/her PHI transmitted directly to another designated person, he/she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Chippewa Falls Area Unified School District
1130 Miles Street
Chippewa Falls, WI 54729
Phone: (715) 726-2417
Fax: (715) 726-2781
Website: https://cfsd.chipfalls.k12.wi.us

Additional Contact Information for HIPAA Questions:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

1. "*Electronic Protected Health Information*" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
2. "Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by Reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    a. Written notice by first-class mail to the Participant (or Next of Kin) at the last known address or, if specified by the Participant, e-mail;
    b. If the Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form;
    c. If an urgent notice is required, the Plan may contact the Participant by telephone.
        i. The Breach Notification will have the following content:
            a) Brief description of what happened, including date of breach and date discovered;
            b) Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
            c) Steps the Participant should take to protect from potential harm;
            d) What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

GENDER AND NUMBER

When used in this Plan, any use of masculine pronouns includes the feminine, any use of the singular includes the plural and vice versa.

AGENCY

Neither the Plan Administrator nor the Claim Administrator is the agent of the other under this Plan for any purpose.

CERTIFICATE OF CORPORATE RESOLUTION

The undersigned [Title] of Chippewa Falls Area Unified School District (the Corporation) hereby certifies that the following resolutions were duly adopted by the board of directors of the Corporation on _____ [Date], and that such resolutions have not been modified or rescinded as of the date hereof;

RESOLVED, that Amendment Number 8 to the Chippewa Falls Area Unified School District Plan effective March 1, 2017 and July 1, 2017 presented to this meeting is hereby approved and adopted and that the proper officers of the Corporation are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the amendment.

RESOLVED, that the proper officers of the Corporation shall act as soon as possible to notify employees of the Corporation of the adoption of this Amendment Number 8 to the Chippewa Falls Area Unified School District Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary Plan Description – Material Modification.

The undersigned further certifies that attached hereto are true copies of Amendment Number 8 to the Chippewa Falls Area Unified School District Plan and Summary Plan Description – Material Modifications approved and adopted in the foregoing resolutions.

_____

[Title]

Date: _____

EDUCATIONAL EXCELLENCE

For a Changing Tomorrow