AMENDMENT #7

Attaching and Forming Part Of The

CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT
EMPLOYEE BENEFIT PLAN

STANDARD PLAN DOCUMENT

Chippewa Falls Area Unified School District – Group #3126 is amending their master plan document **effective March 1, 2017 and July 1, 2017** as follows:

Effective March 1, 2017:

1. (Page 4, 5 and 8) **Schedule of Benefits –** adding for clarification.

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.**

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Cardinal Healthy Primary Care Clinic Services	$25.00 consult fee	
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.	

Effective July 1, 2017:

2. **Plan Document –** amended "Third Party Administrator" and "TPA" to "Claims Administrator" and "Plan Participant" to "Participant" throughout plan document for clarification.

3. (Page 2) **Plan Document –** amended for clarification.

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 are 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 eligible benefits. The Plan Document is maintained by Granite Peak Corporation and may be inspected at any time during normal working hours by any Participant.

4. (Page 3) **Plan Document –** amended for clarification.

Mental Health Parity (Employers with 51 or more Employees are subject to the Federal Mental Health Parity Act)
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.

5. (Pages 5-8) **Schedule of Benefits –** amended for clarification.

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 pre-admission 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 sections ***"Hospitalization Utilization Review Program"*** and ***"Outpatient Pre-Certification"*** for details.

6. (Pages 15-16) **Coverage and Eligibility** amended for clarification.

SPECIAL ENROLLMENT PERIODS

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;

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;

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

D. 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.

7. (Pages 16-17) **GINA –** amended for clarification.

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 detect 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 conditions~~s~~ 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.

8. (Pages 28-29) **Coverage Continuation –** adding for clarification.

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.

9. (Page 29) **Coverage Continuation –** adding for clarification.

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.

10. (Page 31) **Outpatient Pre-Certification –** adding new section after Hospitalization Utilization Review Program section for clarification.

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.

11. (Page 34) **Comprehensive Medical Coverages –** adding for clarification.

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.

12. (Pages 37-40, Item N.) **Covered Expenses –** removing OTC proton pump inhibitors, OTC ophthalmics, OTC Claritin; removing Ranitidine, Cimetidine and Famotidine; removing iron supplements from covered drugs list since they are not mandated prescription drugs;.

N. Prescription Drugs and Medicines

Drugs Covered

~~18. OTC Prilosec, OTC Claritin and OTC Zyrtec, including equivalent agents, covered only with a prescription;~~

18~~19~~. prenatal vitamins requiring a prescription;

~~20. Ranitidine, Famotidine and Cimetidine;~~

19~~21~~. *smoking deterrent medications. Over-the-counter (OTC) requires a prescription;

20~~22~~. *aspirin to prevent cardiovascular disease. Over-the-counter (OTC) requires a prescription;

21~~23~~. *aspirin to prevent preeclampsia. Over-the-counter (OTC) requires a prescription;

22~~24~~. *bowel preps for use in colorectal cancer screening. Over-the-counter (OTC) requires a prescription;

23~~25.~~ *breast cancer chemoprevention medications;

~~26. *iron supplements. Over-the-counter (OTC) requires a prescription;~~

24~~27~~. *oral fluoride supplements. Over-the-counter (OTC) requires a prescription;

25~~28~~. *vitamin D supplements. Over-the-counter (OTC) requires a prescription;

26~~29~~. Tretinoin Topical (e.g., Retin-A);

27~~30~~. female sexual dysfunction drugs, all dosage forms;

28~~31~~. any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

Exclusions

11. OTC Prilosec and equivalent agents; OTC Claritin and equivalent agents; OTC Zyrtec and equivalent agents; and OTC Zaditor and equivalent ~~agents without a prescription~~;

12. Ranitidine, Cimetidine and Famotidine;

13.~~12.~~ 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.~~13.~~ any medication, legend or not, which is taken or administered at the place where it is dispensed;

15.~~14.~~ charges for the administration of or injection of any drug, other than those covered under the preventive benefit;

16.~~15.~~ drugs labeled "Caution – Limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the individual;

17.~~16.~~ 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.~~17.~~ 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.

13. (Page 41, Item R) **Covered Expenses –** amended for clarification.

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.

14. (Page 43, Item Y) **Covered Expenses –** amended for clarification.

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

15. (Page 44-48, Item MM) **Covered Expenses –** amended to clarify mandated preventive benefits.

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

- 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.
- Diabetes screening for adults ages 40 to 70 who are overweight or obese
- 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
- Tuberculosis screening for adults at increased risk

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

- BRCA risk assessment and counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.
- Preeclampsia prevention low-dose aspirin for pregnant women after 12 weeks of gestation who are at high risk
- Sexually transmitted infections counseling for sexually active women
- Syphilis and HIV screening for all pregnant women

Preventive Services for Children

- Bilirubin screening for all newborns
- Depression screening for children ages 12 years and older
- Dyslipidemia screening once between ages 9 and 11 years and once between ages 17 and 21 years
- Hearing screening up to age 21 as indicated by the American Academy of Pediatrics
- HIV screening for children ages 15 to 18~~17~~ years and for younger children who are at increased risk
- Sexually transmitted infections – Intensive behavioral counseling and screening for adolescents
- Tuberculosis testing

16. (Page 48, Item NN) **Covered Expenses –** removing Routine hearing exams from additional preventive services section since it is now a mandated service.

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

- Immunizations for the purpose of travel
- ~~Routine hearing exams for children~~

17. (Page 48, Item OO and PP) **Covered Expenses –** adding for clarification.

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

18. (Pages 49-52, Item 2, 14, 27, 28, 29, 32, 36, 37) **Charges Not Covered –** amended for clarification.

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.

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).

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).

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.

36. services to a 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).

19. **Charges Not Covered –** removed Title XVIII exclusion to not conflict with Coordination of Benefits section and renumbered remaining items.

20. (Page 53) **Charges Not Covered –** adding for clarification.

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.

21. (Page 54, Item I) **Charges Not Covered –** amended heading and added Item I for clarification.

GENERAL EXCLUSIONS AND LIMITATIONS

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.

22. (Pages 57-73) **Definitions –** removed "Scheduled Benefit" since it is no longer needed and amended the following for clarification.

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.

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.

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.

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.

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.

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

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.

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).

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 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.

23. (Page 74) **Coordination of Benefits –** amended for clarification.

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.

24. (Page 74) **Coordination of Benefits –** amended for clarification.

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.

25. (Pages 75-76) **Coordination of Benefits –** amended for clarification.

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.

26. (Page 76) **Coordination of Benefits –** amended for clarification.

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.

27. (Page 77) **Coordination of Benefits –** amended for clarification.

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 ages 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 ages 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.

28. (Page 78) **Health Claim Provisions –** amended for clarification.

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.

29. (Page 79) **Health Claim Provisions –** amended for clarification.

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.**

30. (Page 79-80) **Health Claim Provisions –** amended timeframes per DOL regulations.

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.

31. (Page 80) **Health Claim Provisions –** amended for clarification.

Timing of Claim Decisions

- 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.

32. (Page 85) **Health Claim Provisions –** amended for clarification.

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:

- 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.

33. (Page 86) **Health Claim Provisions –** amended for clarification.

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.**

34. (Page 87) **Health Claim Provisions –** amended for clarification.

External Review Process

A. Scope

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).

35. (Page 87) **Health Claim Provisions –** amended for clarification.

External Review Process

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).

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:

(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 final regulations; and

36. (Page 88) **Health Claim Provisions –** amended for clarification.

External Review Process

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.

37. (Page 90) **Health Claim Provisions –** amended for clarification.

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.

38. (Page 91) **Health Claim Provisions –** amended to remove reference to specific ICD version.

Recovery of Payments
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 Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

39. (Page 91) **Health Claim Provisions –** amended for clarification.

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

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.

40. (Page 92) **Health Claim Provisions –** adding for clarification.

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.

41. (Page 94) **General Provisions –** amended for clarification.

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.

42. (Pages 96-97) **General Provisions –** adding for clarification.

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).

43. (Page 99) **Subrogation/Reimbursement –** amended for clarification.

Subrogation

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.

44. (Page 99) **Subrogation/Reimbursement –** amended for clarification.

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.

45. (Page 103) **HIPAA –** amended for clarification.

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.

46. (Page 104) **HIPAA –** amended for clarification.

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:

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.

47. (Page 105) **HIPAA –** amended for clarification.

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.

48. (Page 108) **HIPAA –** amended for clarification.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

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.

49. (Page 108) **HIPAA –** amended for clarification.

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.

50. (Page 109) **HIPAA –** amended for clarification.

Contact Information

Privacy Officer Contact Information:

51. (Pages 110-111) **HIPAA –** amended for clarification.

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;

All other terms, clauses, conditions and warranties of the insurance to which this amendment is attached remain unchanged.

Chippewa Falls Area Unified School District

by _____
Authorized Representative

Benefit Plan Administrators of Eau Claire, Inc.

by _____
Authorized Representative