AMENDMENT #6

Attaching and Forming Part Of The

CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT
EMPLOYEE BENEFIT PLAN

HDHP PLAN DOCUMENT

Chippewa Falls Area Unified School District – Group #3126 is amending their master plan document **effective July 1, 2016** as follows:

1. **Plan Document –** split HDHP and Standard Plan into two separate plan documents.

2. **Schedule of Benefits –** removed Standard Plan schedule of benefits.

3. (Pages 4-8) **Schedule of Benefits –** amended HDHP in-network coinsurance and max out-of-pocket amounts and amended HDHP preventive benefits sections to clarify mandated preventive 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 (Non-Embedded)	 $1,500 $3,000	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR Individual Family (Non-Embedded)	 $1,750 $3,500	 $2,000 $4,000
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.**

Pre-admission 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. Preadmission Certification should take place prior to a planned admission. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section *"**Hospitalization Utilization Review Program**"* 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
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
Durable Medical Equipment	90% after Deductible	80% after Deductible

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BENEFIT DESCRIPTION	PREFERRED PROVIDER	NON-PREFERRED PROVIDER (Subject to Usual and Customary and Reasonable Charges)
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
Physician Fees for Surgical and Medical Services	90% after Deductible	80% after Deductible

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BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
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.		
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.		

Pre-admission 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. Preadmission Certification should take place prior to a planned admission. Emergency or unplanned admissions may be pre-certified within **two (2) working days** of the admission. See section *"**Hospitalization Utilization Review Program**"* for details.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
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
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

4. (Pages 10-11) **Coverage and Eligibility –** amended for clarification.

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.

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

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.

6. (Page 18) **Coverage and Eligibility –** amended for clarification.

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.

7. (Page 33) **How the Medical Plan Works –** removed reference to Standard Plan.

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, the entire family Deductible must be met before benefit plan coverage takes effect, by any one or a combination of family members. The individual Deductible is not included within the family Deductible.

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.

8. (Page 34, Item B) **Comprehensive Medical Coverages –** amended for clarification.

Comprehensive Medical Expense Coverage Clause

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;

9. (Page 36, Item J) **Covered Expenses –** amended for clarification.

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).

10. (Pages 37-40, Item N) **Covered Expenses –** amended to clarify covered drugs and added clarification for specialty drugs and ancillary charges.

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. OTC Prilosec, OTC Claritin and OTC Zyrtec, including equivalent agents, covered only with a prescription;
19. prenatal vitamins requiring a prescription;
20. Ranitidine, Famotidine and Cimetidine;
21. *smoking deterrent medications. Over-the-counter (OTC) requires a prescription;
22. *aspirin to prevent cardiovascular disease. Over-the-counter (OTC) requires a prescription;
23. *aspirin to prevent preeclampsia. Over-the-counter (OTC) requires a prescription;
24. *bowel preps for use in colorectal cancer screening. Over-the-counter (OTC) requires a prescription;
25. *breast cancer chemoprevention medications;
26. *iron supplements. Over-the-counter (OTC) requires a prescription;
27. *oral fluoride supplements. Over-the-counter (OTC) requires a prescription;
28. *vitamin D supplements. Over-the-counter (OTC) requires a prescription;
29. Tretinoin Topical (e.g., Retin-A);
30. female sexual dysfunction drugs, all dosage forms;
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.

* 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 without a prescription;

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;
13. any medication, legend or not, which is taken or administered at the place where it is dispensed;
14. charges for the administration of or injection of any drug, other than those covered under the preventive benefit;
15. drugs labeled "Caution – Limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the individual;
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;
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.

11. (Pages 44-48, Item MM) **Covered Expenses –** amended to clarify mandated 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.

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
- Aspirin use to prevent cardiovascular disease for men ages 45 to 79 and women ages 55 to 79
- 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 beginning at age 50 and continuing until age 75. Screening includes fecal occult blood testing, sigmoidoscopy, colonoscopy. 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
- Type 2 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)
- 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
- Vitamin D supplements, OTC only, to prevent falls in community-dwelling adults ages 65 and older

Preventive Services for Women, including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- 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 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 for women every 1 to 2 years 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 (81 mg/d) 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.

- Syphilis 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
- 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
- Developmental screening for children under age 3 and surveillance throughout childhood
- Dyslipidemia screening
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening for all newborns
- 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 17 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)
- Iron supplements for children ages 6 to 12 months
- 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 for all sexually active 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
- Tuberculin testing
- Vision acuity screening for all children

12. (Page 48, Item NN) **Covered Expenses –** added to clarify mandated benefits.

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

13. **Definitions –** removed "Embedded" since it is no longer needed.

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

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.

15. (Page 85) **Health Claim Provisions –** amended for correct contact information.

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

16. (Page 87) **Health Claim Provisions –** added for clarification.

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.

17. (Pages 97-101) **Subrogation/Reimbursement –** removed entire section and replaced with the following for clarification:

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)' 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)' 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.

3. 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.

4. 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).

5. 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.

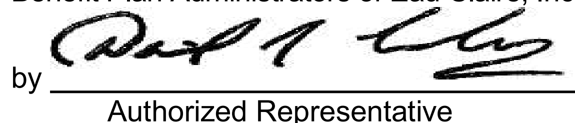
All other terms, clauses, conditions and warranties of the insurance to which this amendment is attached remain unchanged.

Chippewa Falls Area Unified School District

by ___________________________________

Authorized Representative

Benefit Plan Administrators of Eau Claire, Inc.



by ___________________________________

Authorized Representative