SCHOOL DISTRICT OF SPRING VALLEY

MEDICAL AND PRESCRIPTION DRUG BENEFIT PLAN
HSA QUALIFIED HDHP

PLAN DOCUMENT

AMENDED

Effective: 07/01/2021, 01/01/2022, 01/15/2022, 07/01/2022

Non-Grandfathered Health Plan Notice:

This School District of Spring Valley Medical and Prescription Drug Benefit Plan believes that this Plan is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act).

TABLE OF CONTENTS

SCHOOL DISTRICT OF SPRING VALLEY

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by School District of Spring Valley (the "Company or the "Plan Sponsor") as of July 1, 2022 hereby **amends and restates** the School District of Spring Valley Medical and Prescription Drug Benefit Plan (the "Plan"), which was originally adopted by the Company effective October 1, 1984.

Effective Date

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

Adoption of the Plan Document

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

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

School District of Spring Valley

By: _____

Name: _____

Date: _____ Title: _____

Record of Plan Amendments

Amendment Number	Amendment Date	Subject of Amendment
1	September 1, 2011	Termination of Coverage
2	September 1, 2011	Dental Services @ PPO Level
3	September 1, 2011	Eligibility-Claim Filing
4	March 1, 2012	Rx Step Therapy
5	September 1, 2012	Restated as a HDHP/HSA
6	September 1, 2012	Preventive Clarification
7	September 1, 2013	Renewal Updates/Clarifications
8	September 1, 2014	Open enrollment, Renewal updates
9	July 1, 2015	Renewal updates
10	July 1, 2016	Renewal updates
11	May 1, 2017	Open enrollment period change
12	July 1, 2017	Renewal updates
13	July 1, 2018	Renewal updates
14	July 1, 2019	Renewal updates
COVID	March 1, 2020	COVID 19

15	July 1, 2020	Renewal updates
16	July 1, 2020, January 1, 2021, April 1, 2021, July 1, 2021	PBM change, COVID-19 updates, renewal updates
17	July, 1. 2021, January 1, 2022, January 15, 2022, July 1, 2022	Renewal updates, COVID-19 OTC Testing, HHS non-discrimination

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, 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 for eligible benefits. The Plan Document is maintained by School District of Spring Valley and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**School District of Spring Valley Medical and Prescription Drug Benefit Plan**
Plan Sponsor:	**School District of Spring Valley S1450 County Road CC Spring Valley, WI 54767 Phone: (715) 778-5551**
Plan Administrator:	**School District of Spring Valley S1450 County Road CC Spring Valley, WI 54767 Phone: (715) 778-5551**
Group Number:	**3043**
Plan Sponsor ID No. (EIN):	**39-6004579**
Source of Funding:	**Self-Funded**
Plan Year:	**July 1 thru June 30**
Plan Type:	**Medical and Prescription Drug**
Claims Administrator:	**Benefit Plan Administrators of Eau Claire LLC 402 Graham Avenue – 4th Floor Eau Claire, WI 54701 Phone: (715) 832-5535 Phone: (800) 236-7789 Website: www.bpaco.com**

Participating Employer(s): **School District of Spring Valley**

Agent for Service of Process: **School District of Spring Valley**
S1450 County Road CC
Spring Valley, WI 54767
Phone: (715) 778-5551

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

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

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

Non-Discrimination
No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her dependent's/dependents'' health status, medical condition, claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her dependent's/dependents' race, color national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and /or other programs do not constitute discrimination.

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

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

Discretionary Authority

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

IMPORTANT UPDATES REGARDING COVID-19 RELIEF – TOLLING OF CERTAIN PLAN DEADLINES

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 *et seq.* or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1) The 30-day period (or 60-day period, if applicable) to request special enrollment under applicable law, ERISA section 701(f) and Internal Revenue Code section 9801(f);
2) The 60-day election period for COBRA continuation coverage under applicable law, ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3) The date for making COBRA premium payments pursuant to applicable law, ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4) The date for individuals to notify the Plan of a qualifying event or determination of disability under applicable law, ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6) The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7) The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8) The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under applicable law, ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one Calendar Year.

SCHOOL DISTRICT OF SPRING VALLEY
EMPLOYEE BENEFIT PLAN

HSA QUALIFIED HDHP SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
ANNUAL MAXIMUM BENEFIT	Unlimited	
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE Individual Family (Non-Embedded)	 $1,500.00 $3,000.00	
MAXIMUM OUT-OF-POCKET AMOUNT PER PLAN YEAR Individual Family (Non-Embedded)	 $1,500.00 $3,000.00	 $1,750.00 $3,500.00
After the deductible has been satisfied, allowable charges will be paid at 100 percent or 80 percent until the maximum out-of-pocket expense amount is met. Allowable charges from Preferred Providers will be paid at 100 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%: • Pre-Certification penalties • Ineligible charges • Charges in excess of the Plan maximums/limitations • Charges over the Maximum Allowable Charge • Prescription 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.**		

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
2019 Novel Coronavirus (COVID-19)-Diagnostic Tests & Preventive Services	100% Deductible waived	
Ambulance Services	100% after Deductible	
Autism Spectrum Disorder *(therapy services are not subject to visit limitations)*	See specific service as outlined in the Schedule of Benefits *(For example: Physician/Clinic office visit or Therapy Services, et al)*	See specific service as outlined in the Schedule of Benefits *(For example: Physician/Clinic office visit or Therapy Services, et al)*
BPA Direct Contracts	Covered services will be processed at the Preferred Provider level of benefits and subject to all Plan provisions, limitations and exclusions.	
Should a Participant self-pay these services, claims must be submitted by the Participant to the Claims Administrator for consideration at the Preferred Provider level of benefits. Only approved contracted services between BPA and the direct contract providers are allowed under this benefit. All other services are considered based on the network and non-network affiliations of the provider with the Plan.		
Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care. Maintenance Care is **not** covered by the Plan.	100% after Deductible	80% after Deductible
Dental Services Refer to Covered Expenses section.	100% after Deductible	
Durable Medical Equipment	100% after Deductible	80% after Deductible
Emergency Services Includes facility charge, Physician fee and ancillary services.	100% after Deductible	
Hearing Aids Limited to one aid per ear every 36 months. Also includes cochlear implants.	100% after Deductible	80% after Deductible
Home Health Care Plan Year maximum *(excluding autism spectrum disorder therapies).*	100% after Deductible 40 visits	80% after Deductible

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Mental/Nervous Disorders and/or Substance Abuse Inpatient Treatment Including Residential Treatment Facility services Intensive Outpatient, Partial Hospitalization services, psychological testing and other therapies Outpatient Treatment	100% after Deductible	80% after Deductible
Organ Transplants	Refer to United HealthCare Insurance Company Transplant Benefit Policy	Not Covered
Transplant related services and expenses not covered under the UHIC Transplant Benefit Policy will be considered as any other Covered Expense subject to all Plan provisions, limitations and exclusions.		
Physician/Clinic Office Visits other than for Preventive Care	100% after Deductible	80% after Deductible
Prescription Drugs Generic and Brand Name 2019 Novel Coronavirus (COVID-19) Over the Counter (OTC) Testing • Maximum quantity limit 8 tests per Participant per 30 days**	100% after Deductible 100% Deductible waived	80% after Deductible 100% Deductible waived Reimbursement for Non-Preferred Providers is limited to $12.00 per OTC test*
*If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost. **This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.		
For COVID-19 OTC testing reimbursement if you are without your ID card or use a Non-Preferred Provider, you must pay for the prescription and submit a claim to the Prescription Drug Card service.		
Affordable Care Act (ACA) – Preventive drugs are covered 100%, not subject to Deductible or Copay (Generic and single source Brand only).		
For all other reimbursements, if you are without your ID card or at a Non-Preferred Provider, you must pay for the prescription and submit a claim to Benefit Plan Administrators to be considered for reimbursement. 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 the contracted rate less the applicable deductible/coinsurance. Note that no coverage is available for mail order or specialty drugs from a Non-Preferred Provider.		

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Preventive Services Preventive services included under the Affordable Care Act (ACA). *Please note: To comply with statutes and regulations, preventive services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	80% after Deductible
Preventive Care Services Preventive services not included under the Affordable Care Act (ACA).		
• Breast cancer mammography screening coverage is increased to include: a. screenings without age limitations b. digital breast tomosynthesis (DBT/3D mammograms) c. screening mammograms that are converted to a medical diagnosis at the clinical encounter the screening is performed, and any additional mammograms required for clarity	100% Deductible waived	80% after Deductible
• Cervical cancer and dysplasia screening is increased to include screenings without age or frequency limitations	100% Deductible waived	80% after Deductible
• Cholesterol screening coverage is increased to include screenings without age limitations	100% Deductible waived	80% after Deductible
• Diabetes screening coverage is increased to include screenings without age or risk limitations	100% Deductible waived	80% after Deductible
• Prostate-specific antigen (PSA) test	100% Deductible waived	80% after Deductible
• immunizations for the purpose of travel.	100% after Deductible	80% after Deductible

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
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 Maximum benefit	100% Deductible waived One pump in conjunction with each birth	80% after Deductible
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.		
ReforMedicine Services	Covered services, including prescription drugs, received from providers at ReforMedicine will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.	
Renal Dialysis – Outpatient	100% after Deductible	80% after Deductible
Dialysis is a covered service only up to 150% of the regional Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a covered service and are not eligible for reimbursement under the Plan. Covered Expenses will be payable, as shown in the Schedule of Benefits.		
Shared Medical Technology	Covered services, including prescription drugs, received from providers at Shared Medical Technology will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.	
Skilled Nursing Facility	100% after Deductible	80% after Deductible
Maximum per confinement	60 days	
Temporomandibular Joint Dysfunction (TMJ)	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment)*	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment)*

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION (All benefits are subject to the Maximum Allowable Charge)	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Therapy Services	100% after Deductible	80% after Deductible
Plan Year maximum benefit *(excluding autism spectrum disorder therapies)* Physical Therapy Speech Therapy Occupational Therapy	20 visits 20 visits 20 visits	
Urgent Care Includes facility charge, Physician fee and ancillary services.	100% after Deductible	
Virtual Care **E-visit**	100% after Deductible	
Telemedicine	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment.)*	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment.)*
X-ray, Laboratory and Pathology Services other than for Preventive Care	100% after Deductible	80% after Deductible
All Other Covered Expenses	100% after Deductible	80% after Deductible

TRANSPLANT BENEFITS

Your health plan includes benefits for human organ and tissue transplantation, which are fully explained in your United HealthCare Insurance Company (UHIC) Transplant Benefit Policy and Certificate of Coverage. Human organ or tissue transplant services for eligible employees and dependents are covered under this fully-insured policy, according to its terms and conditions. Coverage under the UHIC policy for the transplant and transplant-related services begins on the day before the transplant is performed and continues through and until the 365th day after the transplant. In addition to the transplant procedure itself, other covered services include the evaluation, search and registry, certain donor services, and anti-rejection drugs. Some of the services may be Incurred outside of the 365-day benefit period.

The terms of the fully insured plan document determine how the following are covered under your group medical plan:

- Transplant-related health services received before and after the "benefit period" as defined in the UHIC Certificate of Coverage;
- Any other transplant related expenses not covered under the UHIC Certificate of Coverage; and
- Health care services, received at any time, which are not related to a transplant.

If you have any questions, please contact your OptumHealth Case Manager at the toll free number listed in your Transplant Plan Document.

UTILIZATION REVIEW PROGRAM

Utilization review is the process of evaluating if services, supplies or treatment are Medically Necessary and appropriate to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations and shorten confinements while improving quality of care and reducing costs to the Participant and the Plan.

Contact the utilization review organization by **CALLING THE 800-NUMBER LISTED ON YOUR HEALTH BENEFITS IDENTIFICATION CARD FOR CERTIFICATION.**

The following services REQUIRE pre-certification:

All Inpatient Admissions

- Hospital
- Maternity if length of stay that is greater than 48 for a vaginal delivery or 96 hours for a cesarean delivery.
- Skilled Nursing Facilities
- Mental/Nervous Disorders and/or Substance Abuse services (inpatient and residential)

Outpatient

- Chemotherapy/Radiation Therapy at a facility or Physician's office
- Dialysis

IMPORTANT: PRE-CERTIFICATION DOES NOT VERIFY OR GUARANTEE COVERAGE. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS, LIMITATIONS AND EXCLUSIONS.

HOW THE PROGRAM WORKS

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

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

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

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

B. **"EMERGENCY or URGENT CARE ADMISSIONS"** or hospitalizations for potentially life-threatening causes are exempt from the pre-admission certification requirement. However, following an Emergency or Urgent care admission, certification must be obtained within 48 hours following the admission or on the first business day following weekend or holiday admission.

C. **"MATERNITY ADMISSIONS"** Group health plans generally may not, under Federal law (the Newborns' and Mothers' Health Protection Act), restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under Federal law require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

If your maternity stay admission exceeds the periods stated above, Your utilization review organization must be contacted within 24 hours or the next business day, whichever is sooner, or benefits otherwise payable will be subject to the penalty described under "Pre-Certification Penalty".

D. **"OUTPATIENT SERVICES"** Certain Outpatient services as listed above must be pre-certified in advance of the proposed procedure in order for full Plan benefits to be payable. The Participant or their representative should call the utilization review organization at least three (3) business days prior to the performance of the procedure

After admission to the Hospital, the utilization review organization will continue to evaluate the Participant's progress through concurrent review to monitor the length of confinement and Medical Necessity of treatment. If the utilization review organization disagrees with the length of confinement recommended by the Physician, the Participant and the Physician will be advised. If the utilization review organization determines that continued confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as Medically Necessary by the utilization review organization shall be denied.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to pre-certify the required services as identified above, **the allowed charges will be reduced by 25% up to a maximum of $250.00 per occurrence.** This penalty does not apply to the deductible or maximum out-of-pocket expenses. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

COMPREHENSIVE MEDICAL COVERAGES

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

COMPREHENSIVE MEDICAL EXPENSE COVERAGE CLAUSE

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

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

PROVIDER PROVISIONS

A. Expenses for obtaining medical records will be paid in full to a maximum benefit of $100.00 per provider.
B. Due to the constant changes to the provider network, it is always a good idea to verify that your provider is still part of the network at the time you make your appointment.
C. Any charges in excess of the Maximum Allowable Charge will not be considered eligible for payment.
D. All providers contracted with the PPO Preferred Provider Network as identified on your health benefits identification card or directly with the Plan through BPA/Valenz (including dialysis) will be considered “Preferred Providers”. Covered expenses incurred by “Preferred Providers” (hospital or physician) will be covered at a higher rate than “Non-Preferred Providers”, except as outlined in the “No Surprises Act – Emergency Services and Surprise Bills” provision below.

   Additional Preferred Provider Organizations, negotiation services or MultiPlan’s Data iSight Solutions (before or after services are rendered) may be utilized in order to optimize coverage and preserve plan assets. When this occurs, the covered charges may be paid at the “Preferred Provider” rate. Please note that providers’ status may change between Preferred and Non-Preferred at any time.

E. If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is a Preferred Provider and the Participant receives such item or service in reliance on that information, the Participant’s coinsurance, Copay, deductible, and out-of-pocket maximum will be calculated as if the provider had been a Preferred Provider despite that information proving inaccurate.

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Preferred Provider claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Preferred Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits providers from pursuing Participants for the difference between the Maximum Allowable Charge and the provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward Preferred Provider deductibles and out-of-pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-Emergency services rendered by a Non-Preferred Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Preferred Provider air ambulance services.

SERVICES AND SUPPLIES

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

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED CHARGES

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

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

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

BALANCE BILLING

In the event that a claim submitted by a Preferred or Non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many situations, 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.

CONTINUITY OF CARE

In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is a Preferred Provider or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific provider,
2) is undergoing a course of institutional or Inpatient care from a specific provider,
3) is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
4) is pregnant and undergoing a course of treatment for the pregnancy from a specific provider, or
5) is or was determined to be terminally ill and is receiving treatment for such Illness from a specific provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the provider to continue to accept the previously contracted amount, the contract itself will have terminated and thus the Plan may be unable to protect the Participant if the provider pursues a balance bill.

COVERED EXPENSES

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

A. **Allergy Treatment.** Charges only for those allergy tests and treatments that contemporary medical consensus considers safe and effective. The Plan does not cover unproven or unconventional services even when prescribed by a Physician. In determining whether allergy services are covered, the Plan relies on the standards of the American Academy of Allergy, Asthma, and Immunology (AAAAI). Thus, the Plan will only cover services that meet AAAAI's standards. The Plan encourages you to share this information with your Physician when you decide on a treatment plan. Examples of services the Plan will cover if they are performed according to the standards of the AAAAI:

1. Initial diagnostic evaluation. This includes the initial history, physical examination, relevant laboratory services, and the following diagnostic tests to determine the cause of the allergy:

    a. scratch tests or specific intradermal tests, if warranted by the patient's history and physical examination.

    b. specific laboratory tests to determine respiratory function and blood levels of the immune system.

    c. in vitro (via a blood sample) allergy tests if skin testing is not conclusive, if the patient has a condition that precludes the use of scratch testing or intradermal tests, or if these tests are used in lieu of scratch or intradermal testing.

2. Injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis.

B. **Ambulance Services.** Transportation charges including commercial ground or air ambulance service to transport the patient:

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

2. when Medically Necessary.

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

D. **Ancillary Services.** Charges for medical care and services provided by a:

1. Radiologist;

2. Pathologist;

3. Laboratory for diagnostic laboratory and x-ray examination.

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

E. **Approved Clinical Trial.** Charges for a qualified individual for routine costs of an Approved Clinical Trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the Affordable Care Act (ACA), when the routine costs would be a Covered Expense if provided outside of the Approved Clinical Trial. This excludes:

1. the Investigational item, device or service itself.

2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

F. **Autism.** Charges for the diagnosis and treatment of or in connection with autism spectrum disorder (ASD) which includes autistic disorder, Asperger's syndrome and any pervasive developmental disorder not otherwise specified. Applied behavior analysis (ABA), Occupational, Physical, and Speech Therapy are included for rehabilitative care and care deemed habilitative or non-restorative. Does not include services that are Experimental or Investigational, or otherwise not covered by the Plan.

G. **Chiropractic Treatment.** Chiropractic therapy as follows:

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

Maintenance Care is Routine and is not Medically Necessary for the treatment of a condition. Maintenance Care is **NOT** covered by the Plan.

H. **Contraception/Surgical Sterilization Services.** All safe and effective drugs, medications (refer to prescription drug benefit) and devices in general use as contraceptives that require a prescription or intervention by a Physician or other licensed health care provider. Examples include birth control pills, Norplant or similar contraceptives, Depo Provera, injectible contraceptives, intrauterine devices (IUDs), cervical caps and diaphragms.

Necessary services of a Physician or other licensed health care provider in connection with covered contraception. Such services include assessment, diagnosis, administration, insertion or prescription.

Surgical sterilizations such as tubal ligations and vasectomies.

Refer to the Preventive Benefit Section for those services which are included within the Affordable Care Act and not subject to cost sharing.

I. **Dental Services.** The Plan will cover only these dental services:

1. The initial treatment required to repair and restore the functioning of sound, natural teeth that have been *injured*. The term *injured*, as used here, does not include dental conditions resulting from eating, biting, disease, or decay. A *sound, natural tooth* is one that is organic, not manufactured. Therefore, bridges, implants, crowns, and dentures are not natural teeth. Any service for, or in connection with, their restoration and repair is not covered under this Plan.

2. Oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with a services that is covered by this Plan; for example, removal of impacted wisdom teeth.

3. Hospital and Ambulatory Surgical Center charges, including Anesthesia charges, if you must receive dental care in one of these setting you have a chronic Disability or medical condition that requires Hospitalization or general Anesthesia for dental care.

4. In addition to the Plan covering extraction of natural teeth, charges for the following services due to the extraction/replacement of natural teeth:

   a. the initial replacement of the extracted natural teeth;

   b. the replacement of previously existing fixed bridgework if replacement is required due to the extraction of one or more natural teeth that are:
      (i) adjacent to the fixed bridgework, or
      (ii) abutment teeth supporting the existing bridgework.

   c. the replacement of previously existing partial removable dentures:
      (i) if replacement is required due to the extraction of one or more natural teeth, and
      (ii) the existing partial denture is no longer serviceable and cannot be made serviceable.

J. **Diabetes.** Insulin infusion pumps, other equipment and supplies (which are not covered under the prescription drug program) including blood glucose testing monitors and continuous glucose monitors (CGMs) including sensor, transmitter and receiver and diabetic self-management education programs. One pump is covered per year and the pump must be in use 30 days before purchase. For prescribed drugs, refer to the prescription drug benefit section.

K. **Durable Medical Equipment and Supplies.** Charges (purchase or rental depending on economic justification) for orthopedic or prosthetic devices, supplies and hospital type equipment for:

1. the initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

   a. due to the growth or development of a dependent Child; or

   b. when necessary because of a change in the Participant's physical condition; or

c. because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to the prior approval by the Plan. Equipment containing features of a cosmetic nature or features of a medical nature which are not required by the Participant's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the Participant's medical needs.

2. dressings, sutures or other necessary medical supplies.

3. orthopedic appliances. Examples are custom made orthotics prescribed by a Physician, casts, splints, trusses, braces, and crutches for short-term or long-term use.

4. oxygen and other gases and their administration, rental of equipment for giving oxygen, rental of equipment to aid in breathing, iron lung, specialized feeding equipment or other Durable Medical Equipment required for temporary therapeutic use, wheelchair or hospital bed.

5. dialysis equipment rental, supplies, upkeep and the training of the Participant or the one who attends him to run the equipment.

6. ostomy care items, catheter maintenance supplies, and surgical stockings (for example, Jobst stockings).

7. functional repair of Durable Medical Equipment.

8. supplies necessary for the proper mechanical operation of equipment.

The following are examples of equipment and supplies that are not covered:

1. routine maintenance of equipment.

2. repair or replacement of equipment damaged because of negligent use or abuse.

3. equipment or supplies to facilitate participation in physical activity or sports.

4. over-the-counter (OTC) supplies except as specifically provided in the Plan

L. **Hearing Services.** Covered hearing-related services are limited to:

1. diagnostic tests to establish or confirm a hearing loss and determine the cause.

2. treatment of hearing pathology caused by an Illness or Injury.

3. surgery to repair malformed or malfunctioning hearing-related structures.

4. Cochlear implants, but **only** if the Plan has approved both the evaluation services and the implant procedures in advance.

5. hearing aids for a Participant who is certified as deaf or hearing impaired by a Physician or licensed audiologist, but only if the Plan has approved the hearing aid in advance.

   A hearing aid is an instrument or device, including related parts, attachments, or accessories, that is worn externally and designed to aid or compensate for impaired hearing. The Plan will cover the examinations, tests, or services for prescribing or fitting a hearing aid or device. The benefit is limited to one hearing aid per ear in each three-year period.

M. **Home Health Care**. Eligible charges are covered by the Plan if approved in writing by an attending Physician as follows:

1. part-time nursing care or home health aide services Medically Necessary and under the supervision of or provided by a Registered Nurse or medical Social Worker;

2. Physical, respiratory, Occupational or Speech Therapy;

3. medical supplies, drugs and medications prescribed by a Physician (refer to prescription drug benefit) and laboratory services provided by or on behalf of a Hospital. These items are covered only if they would have been provided if confined in a Hospital;

4. home infusion services;

5. prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems. The plan will cover food substitutes used for enteral nutrition when they are the only source of nutrition and the need is Medically Necessary.

6. nutrition counseling where necessary and under the supervision of or provided by a registered dietician;

7. evaluation for the need and the development of a plan made by a Registered Nurse, Nurse Practitioner, Physician Assistant, or medical Social Worker;

8. each visit by any of the above providers is for up to 4 hours in any 24-hour period and up to a maximum of 40 visits per Plan Year *(excluding autism spectrum disorder therapies).* In no event will more be paid than would have been paid had treatment been provided in a Skilled Nursing Facility during any weekly period.

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

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

1. nursing care by a Registered Nurse, a Licensed Practical Nurse, a Licensed Vocational Nurse or a public health nurse who is under the direct supervision of a Registered Nurse;

2. Physical Therapy and Speech Therapy when rendered by a licensed therapist;

3. medical supplies, including drugs and biologicals and the use of medical appliances;

4. Physician's services;

5. services, supplies and treatments deemed Medically Necessary and ordered by a licensed Physician;

6. counseling for the patient and the patient's immediate family. Services must be given by a licensed Social Worker. For this benefit, "immediate family" means you or any member of your family who is covered under this Plan.

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

1. six months from the date of acceptance into the Hospice program; or

2. the death of the Participant.

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

O. **Hospital Care.**

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

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

3. Special Hospital charges for Inpatient medical care or supplies received during any period for which there are Room And Board charges with the exception of private nursing care.

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

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

P. **Infertility Treatment.** Charges for infertility treatment are limited to the initial diagnosis and testing of infertility (the inability to conceive). Once a diagnosis has been rendered, no further diagnostic tests are covered unless they are reasonably expected to reveal another clinical cause for infertility.

Charges for surgical procedures necessary to repair or restore a malformed or malfunctioning body part or process found to be the cause of infertility in order to enable natural conception. **Note:** The reversal or tubal ligations and vasectomies are not covered.

Any treatment, drugs or procedures for the promotion of conception will not be considered eligible (i.e., in-vitro fertilization, GIFT, artificial insemination, etc.).

Q. **Mastectomy.** Charges in connection with a mastectomy, in accordance with the Women's Health and Cancer Rights Act including:

1. reconstruction of the breast on which the mastectomy has been performed;

2. surgery and reconstruction of the other breast to produce symmetrical appearance; and

3. coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas.

R. **Mental Health and Substance Abuse.** Treatment of Mental or Nervous Disorders and Substance Abuse Benefits. Benefits are available for Inpatient or Outpatient care for Mental or Nervous Disorders and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the diagnosis when rendered by any of the following:

Doctor of Medicine (MD).
Licensed Clinical Psychologist (PhD).
Licensed Clinical Psychiatric Social Worker (LCSW).
Licensed Professional Counselor (LPC).
Registered Nurse Clinical Specialist (RNCS).

Benefits are available for Residential Treatment Facility, Partial Hospitalization, Intensive Outpatient Services and prescribed drugs (refer to prescription drug benefit)

S. **Nutrition Counseling.** Charges as prescribed by a Physician, while confined as an Inpatient in a Hospital, under the supervision of or provided by a registered dietician.

T. **Pregnancy/Maternity and Newborn Care.** Covered Expenses for pregnancy/maternity care including a surrogate pregnancy will be payable on the same basis as Covered Expenses for all other Illness with respect to all women covered under the Plan. The Plan will reimburse for special diagnostic services for one or both parents in high-risk circumstances. No charges are covered for surrogate pregnancy if the pregnant individual is not a Participant under the Plan.

1. prenatal care. This includes physical examination, Pap test, laboratory tests, and HIV antibody test. (Refer to the Preventive Benefit Section for prenatal care that is considered under the Affordable Care Act (ACA) Women's Preventive Services.)

2. Physician services related to labor, delivery and postpartum care.

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

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

   a. Room And Board charged by a Birth Center;

b. charges for Other Services and Supplies;

c. Anesthetics and charges for giving them.

5. Hospital Room And Board.

6. Elective induced abortions when Medically Necessary to safeguard the life of the mother or due to complications with the Pregnancy, or the Pregnancy is the result of rape or incest. Treatments of complications that arise after an abortion are covered, whether or not the abortion was Medically Necessary.

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 (the Newborns' and Mothers' Health Protection Act) 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).

Covered Special Services When a Pregnancy Exists. The Plan will cover amniocentesis, genetic testing, genetic counseling, and chromosome studies if any of these circumstance exist:

1, the pregnant woman is 35 or older.

2. the pregnant woman or her mate has a family history of a highly disabling hereditary disorder or has previously had a Child with such a disorder.

3. the pregnant woman has previously experienced a miscarriage or stillbirth.

4. the pregnant woman is a known carrier of a genetic abnormality or disease.

5. the pregnant woman was exposed, before or during pregnancy, to diseases or chemicals strongly linked to Birth Defects, or the pregnant woman's mate was exposed to such disease or chemicals before the pregnancy began.

Covered Special Services When No Pregnancy Exists. The Plan will cover genetic testing, genetic counseling, and chromosome studies that are expected to reveal new information relevant to the decision to have a Child if any of these circumstances exist:

1. the woman or her mate has a family history of a highly disabling hereditary disorder.

2. the woman or her mate is a known carrier of a genetic abnormality of disease.

3. the woman or her mate has previously had a Child with a genetic disorder, abnormality, or disease.

4. the woman has had multiple miscarriages or stillbirths.

Newborn Services. Covered newborn services include:

1. services required by a newborn immediately after birth including care and treatment for pre-term or premature birth, low birth weight, Respiratory Distress Syndrome (RDS), failure to thrive, and abnormal or inadequate liver function.

2. treatment of congenital defects and birth abnormalities including functional repair necessary to achieve normal body function. However, the Plan does not cover cosmetic surgery performed only to improve a newborn's appearance.

3. routine or “well baby” Physician visits after birth. See “Preventive Care” for more details.

U. **Prescription Drugs and Medicines.**

Definitions apply to this benefit only:

Ancillary Charge: an additional charge required when the Participant chooses a non-preferred formulary medication for which a generic alternative is available. The Ancillary Charge is calculated as the difference between the non-preferred formulary 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 Benefit Manager 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 Benefit Manager: an organization that manages payment for Prescriptions and services under the Plan.

Additional Charges
If you request a non-preferred brand medication when there is a generic available, you will be required to pay the difference in cost between the generic and the non-preferred brand medication (Ancillary Charge) in addition to the non-preferred brand cost.

Cost-Sharing Limitations
Pursuant to Wisconsin Statute § 632.861 (3), the amount the pharmacy benefit manager can require a Participant to pay for a prescription drug at point of sale is restricted to be the lower of the cost-sharing amount under the terms and provisions of this Plan or the amount the Participant would pay without using this Plan’s prescription drug coverage.

Caremark SpecialtyRx

Caremark Specialty Pharmacy Service is provided by a Caremark specialty pharmacy entity or its affiliate, Caremark SpecialtyRx, and allows distribution for certain pharmaceutical products that are generally biotechnological in nature, are given by injection, or otherwise require special handling. Caremark Specialty Rx will be the exclusive participating pharmacy that provides Specialty Medications to Participants. All other pharmacies supplying Specialty Medications will be considered non-participating pharmacy providers. Specialty Medications procured from a participating medical provider rather than a pharmacy will be considered in-network, and Specialty Medications procured from a non-participating medical provider rather than a pharmacy will be considered out-of-network. Specialty Medications are those medications which Specialty Pharmacy Services distributes for treatment of patients with narrow-niche, high-cost, chronic conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia, growth hormone deficiency, alpha 1-antitrypsin disorder, and other special medical conditions. Products provided are typically injectible drugs but may also include infusion drug products, as well as oral or inhaled drugs. If you require additional information concerning SpecialtyRx, please contact the Claims Administrator or visit www.cvscaremarkspecialtyrx.com.

Specialty drugs require Prior Authorization before coverage can be confirmed. This is a process through which your Physician confirms with a Caremark pharmacist that your prescription is appropriately prescribed for safety, effectiveness for your stage of Illness and Medical Necessity. The CaremarkConnect® specialty team will work with your Physician to perform this review when you order a specialty prescription. CaremarkConnect® can be reached at (800) 237-2767. If your specialty prescription does not meet the criteria for approval, you and your Physician will receive a letter from Caremark instructing you how you may file an appeal.

Caremark Formulary Strategy

Development and management of a drug formulary is an integral component in the pharmacy benefit management services provided by Caremark. Formularies have two primary functions: 1) to help plans manage drug spend through the appropriate use and selection of drug therapies; and 2) to allow Caremark to negotiate with drug manufacturers for the lowest net cost for formulary brand products to help manage spend.

This Plan has adopted a formulary, including a preferred drug list, as the Plan's covered formulary. Drugs determined as "non-formulary" are not covered by the Plan. Non-formulary drugs are drugs with a history of extreme price inflation, manufacturer couponing tactics, and other such tactics that have resulted in unnecessary, unjustified cost increases for plans. In all cases, non-formulary items have a clinically appropriate formulary alternative, many of which are generic.

Caremark has implemented a proactive communication campaign to ensure enough lead time – approximately 6 weeks – to make you aware of any upcoming formulary change and the lower cost generic and formulary brand alternative available to you. If you require additional information concerning the preferred drug list or a non-formulary drug, please contact the Claims Administrator or visit www.caremark.com.

Caremark Performance Generic Step Therapy

In order to have coverage for some brand prescription medications in certain drug classes, you first must try a proven, cost-effective generic alternative within the drug class, if available, to treat your condition. If you try (or have tried) a generic drug recently and it does not work for you, then you may receive coverage for a brand drug that your Physician prescribes. Coverage for use of a non-preferred brand drug without recently trying a generic first would need prior authorization from Caremark. Coverage may be denied and you may have to pay the full retail cost of the brand drug.

Dispensing Limitations – Retail and Mail Order

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

*COVID-19 Over the counter (OTC) tests will not exceed 8 tests per Participant per 30 days. **This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.

Drugs Covered

(For a complete list of covered drugs, contact the Pharmacy Benefit Manager shown on your identification card.)

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, except drugs not covered under this Plan;
2. All compounded medication of which at least one ingredient is a legend drug (compound medications may require a preauthorization, and if applicable, will be handled automatically when a compound medication is processed online by the prescription benefit manager); Exceptions: See Exclusion list below;
3. **AIDS/HIV**-related drugs;
4. **Amphetamines;**
5. **Anabolic steroids**;
6. ***Aspirin** to prevent cardiovascular disease and colorectal cancer. Over-the-counter (OTC) requires a prescription;
7. ***Aspirin** to prevent preeclampsia. Over-the-counter (OTC) requires a prescription;
8. ***Bowel preps** for use in colorectal cancer screening. Over-the-counter (OTC) requires a prescription;
9. ***Breast cancer chemoprevention medications**;
10. ***Contraceptives**, oral or other, whether medication or device. Over-the-counter (OTC) requires a prescription;
11. **Diabetic supplies** disposable insulin needles/syringes; lancets; insulin injection devices, disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape);
12. **Emergency allergic** reaction kits;
13. ***Fluoride oral supplements**. Over-the-counter (OTC) requires a prescription;
14. ***Folic acid supplements**. Over-the-counter (OTC) requires a prescription;
15. **Gender Dysphoria.** Medications for treatment related to gender dysphoria.
16. **Growth hormones** (requiring prior authorization);
17. ***Immunizations** (refer to Preventive Care services);
18. **Insulin** when prescribed by a Physician;
19. ***Iron supplements**. Over-the-counter (OTC) requires a prescription;
20. **Over-the-counter medications** requiring a prescription: loratadine (generic Claritin) for allergies and OTC Zyrtec (cetirazine); Alaway and Zaditor for itchy eyes; and Prevacid 24 HR, omeprazole OTC and Prilosec OTC for heartburn or upset stomachs;
21. **Prenatal vitamins** requiring a prescription;
22. ***Smoking deterrent medications**. Over-the-counter (OTC) requires a prescription;
23. *statin preventive medicine;
24. **Vitamin A** derivatives for dermatological/cosmetic use (e.g., Retin-A, Renova) thru the age of 25;
25. ***Antiretroviral therapy**- preexposure prophylaxis (PrEP) for persons who are at high risk of HIV;
26. **2019 Novel Coronavirus (COVID-19) Over the Counter (OTC) Testing** (quantity limits apply).

*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.

Exclusions

(For a complete list of exclusions, contact the Pharmacy Benefit Manager shown on your identification card.)

1. Any medication, legend or not, which is taken or administered at the place where it is dispensed;
2 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.
3. Drugs labeled "Caution – Limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the individual;
4 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;
5. **Acne medication.** Charges for topical acne products for a Participant who is age 26 or over, except for the treatment of acute acne;
6. **Administration.** Any Charge for the administration of or injection of any covered drug;
7. **Anorectics.** (any drug used for the purpose of weight loss);
8. **Anti-wrinkle agents.** (e.g., Renova) regardless of intended use;
9. **Appetite suppressants.** A charge for dietary supplements, anti-obesity drugs or vitamin supplements;
10. **Blood glucose monitors** and continuous glucose monitors (CGMs) including sensor, transmitter and receiver;
12. **Cosmetic.** Charges for Tretinoin Topical (e.g., Retin-A) for individuals 35 years of age or older unless Medically Necessary;
13. **Dermatologicals.** Hair growth stimulants;
14. **Dietary supplements**;
15. **Immunization agents.** Or biological sera, blood or blood plasma except specifically listed above;
16. **Infertility** medications
17. **Non-legend drugs.** Except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;
18. **Over-the-counter medications.** Any charges for over –the-counter medications except specifically listed above.
19. **Refills.** Charges for refills of a prescription that is more than one (1) year old;
20. **Sexual dysfunction.** Drugs for sexual dysfunction (i.e., Viagra);
21. **Smoking deterrent medications.** Containing nicotine or any other smoking cessation aids, except specifically listed above;
22. **Therapeutic devices.** Appliances or devices, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;

23. **Vitamins.** Singly or in combination except specifically listed above.

V. **Preventive Care Services.** Preventive Care services to comply with the Affordable Care Act (ACA), and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

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/womens-guidelines

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

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

Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked
- Alcohol unhealthy alcohol use screening and counseling
- Blood pressure screening
- Bowel preps for use in colorectal cancer screening for adults ages 45 to 75
- Cholesterol screening for adults ages 40 to 75
- Colorectal cancer screening for adults ages 45 to 75. Screenings include but are not limited to Cologuard (sDNA-FIT), colonoscopy, CT colonography, flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, gFOBT, FIT, and other tests and procedures that are medically recognized and are non-Experimental/Investigational in nature. This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.
- Depression screening
- Diabetes screening for adults ages 35 to 70 who are overweight or obese
- Diet and physical activity behavioral for adults with cardiovascular disease risk factors
- Drug use, unhealthy drug use screening

- Hepatitis B screening for adults at high risk for infection
- Hepatitis C virus (HCV) infection screening for adults aged 18 to 79 years
- HIV screening for adults ages 18 to 65 and for older adults who are at increased risk
- Immunization vaccines for adults – Doses, recommended ages and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster (shingles)
  - Human Papillomavirus (HPV)
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Tetanus, Diphtheria, Pertussis (whooping cough)
  - Varicella (chicken pox)
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults ages 50 to 59 who are at increased risk of cardiovascular disease
- Lung cancer annual screening with low-dose computed tomography in adults ages 50 to 80 who have a 20-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
- Preexposure prophylaxis (PrEP) with antiretroviral therapy to persons who are at high risk of HIV. This also includes coverage of associated testing for HIV, Hepatitis B and C, creatinine, pregnancy, and sexually transmitted infection, as well as adherence counseling, and associated office visits.
- Prevention of falls – exercise interventions for community-dwelling adults ages 65 and older who are at risk for falls
- Sexually transmitted infections – 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
- Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- Syphilis screening for adults at increased risk
- Tuberculosis screening for adults at increased risk
- Tobacco use screening and behavioral interventions and FDA-approved pharmacotherapy for cessation for all adult tobacco users

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

- Bacteriuria urinary tract or other infection screening for pregnant women
- Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain during pregnancy.
- BRCA risk assessment and counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.
- Breast cancer chemoprevention counseling and medications for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women ages 40 and over

- Breast feeding support, supplies 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. If a breast pump is purchased from a retail store it will be paid at the Preferred Provider level of benefits. Purchases from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement.
- Cervical cancer and dysplasia screening for women ages 21 to 65 with cytology (Pap smear) every 3 years. For women aged 30 to 65 years every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (contesting). Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
- 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. (not including abortifacient drugs used for non-surgical abortions).
- Depression counseling and intervention for all pregnant and postpartum persons who are at increased risk.
- 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
- Osteoporosis screening for women ages 65 and older and in post-menopausal younger women who are at increased risk, as determined by a formal clinical risk assessment tool.
- Preeclampsia screening and prevention in pregnant women with blood pressure measurements throughout pregnancy and low-dose aspirin after 12 weeks of gestation for those who are at high risk
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care. Also repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative.
- Sexually transmitted infections counseling for sexually active women
- Syphilis and HIV screening for all pregnant women
- Tobacco use screening and behavioral interventions for cessation for all pregnant women who use tobacco
- Well-woman visits – Visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Frequency: Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors.

Preventive Services for Children

- Alcohol and drug use assessments
- Anemia (iron-deficiency) screening on a routine basis.
- Autism spectrum disorder screening for children at 18 and 24 months
- Behavioral assessments
- Bilirubin screening for all newborns

- Blood pressure screening
- Congenital hypothyroidism screening for all newborns
- Critical congenital heart disease screening for all newborns
- Dental caries prevention up to age 5 – Limited to fluoride varnish to primary teeth and oral fluoride. Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
- Depression screening for children ages 12 years and older
- Developmental screening for children under age 3 and surveillance throughout childhood
- Dyslipidemia screening once between ages 9 and 11 years and once between ages 17 and 21 years
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening up to age 21 as indicated by the American Academy of Pediatrics
- Height, weight and Body Mass Index measurements
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for children at high risk for infection
- HIV screening for children ages 15 to 18 years and for younger children who are at increased risk
- Immunization vaccines for children from birth to age 18 – Doses, recommended ages and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis (whooping cough)
  - Haemophilus influenza type b (Hib disease)
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (HPV)
  - Inactivated Poliovirus
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Rotavirus
  - Varicella (chicken pox)
- Lead screening
- Medical history
- Obesity screening for children ages 6 years and older followed by comprehensive, intensive behavioral interventions to promote improvement in weight status
- Oral health risk assessment
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infections – 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
- Tuberculosis testing
- Vision acuity screening for all children

W. **Preventive Care Services.** The Plan shall cover the following non-Affordable Care Act (ACA) Preventive Care services as outlined in the Schedule of Benefits:

- Breast cancer mammography screening coverage is increased to include:
  a. screenings without age limitations
  b. digital breast tomosynthesis (DBT/3D mammograms)

c. screening mammograms that are converted to a medical diagnosis at the clinical encounter the screening is performed and any additional mammograms required for clarity

- Cervical cancer and dysplasia screening is increased to include screenings without age or frequency limitations
- Cholesterol screening coverage is increased to include screenings without age limitations
- Diabetes screening coverage is increased to include screenings without age or risk limitations
- Prostate-specific antigen (PSA) test
- Immunizations for the purpose of travel

X. **Professional Services.** When performed by a properly licensed/certified Health Care Professional, while acting within the scope of his or her license/certificate:

1. charges for medical care and services made by a Physician;

2. nursing services of an R.N., on their own behalf, in or out of a Hospital, if Medically Necessary;

3. nursing services of an L.P.N. or L.V.N., on their own behalf, in a Hospital, if such services are prescribed by a Physician;

4. other provider of service, as determined eligible by the Plan and subject to Medical Necessity, who is duly licensed, if applicable, by the state or regulatory agency responsible for such licensing in the state in which the individual performs services.

A nurse or Health Care Professional must not be a Close Relative or one who has the same legal residence as the Participant.

Y. **Renal Dialysis.** Charges for outpatient renal dialysis services. Dialysis is a covered service only up to 150% of the regional Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a covered service and are not eligible for reimbursement under the Plan. Covered Expenses will be payable, as shown in the Schedule of Benefits.

Z. **Sales Tax**. Sales tax, if any, on Medically Necessary services

AA. **Sex assignment/sex reassignment.** Charges related to a sex assignment/sex reassignment surgery.

BB. **Skilled Nursing Care.** 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 60 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.

CC. **Surgical Services.** Surgery and Anesthesia charges of a Physician and for the giving of Anesthesia, however, charges which relate to cosmetic, plastic, reconstructive or restorative surgery shall be payable only if Incurred for the repair of a disfigurement caused from any of the following:

1. an accidental Injury;

2. a Birth Defect;

3. as the result of a covered surgical procedure.

The Plan will follow CMS Physician Fee Schedule and NCCI guidelines in determining procedures subject to multiple surgical procedure reductions as follows:

a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Maximum Allowable Charge that is allowed for the primary procedure; each additional procedure performed through the same incision will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Maximum Allowable Charge allowed for that procedure; and

c. If an assistant surgeon is required, the assistant surgeon's covered charge will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines.

DD. **Surrogate Mother.** Charges for treatment, services or supplies for a surrogate mother or any pregnancy for a Participant's service as a surrogate mother.

EE. **Temporomandibular Joint Dysfunction Treatment (TMJ).** The Plan will reimburse only for:

1. TMJ treatments, surgical and non-surgical if approved by the Plan.

2. TMJ testing that contemporary medical consensus considers safe and effective.

The Plan will not cover unproven or unconventional services even when recommended or prescribed by a Physician. In determining what services contemporary medical consensus considers to be safe and effective, the Plan will rely on the standards of the medical organization that represents the profession of the provider from whom you receive the services; for example, the American Academy of Orofacial Pain (AAOP). Thus, the Plan may not cover all recommended treatment.

Examples of covered services include:

1. initial diagnostic evaluation. This includes initial history, physical examination, and relevant laboratory and diagnostic services. The following diagnostic services are covered if they are responsible to your specific symptoms, likely to yield additional information useful for planning treatment, and not redundant with other diagnostic procedures:

a. Panoramic or TMJ tomography, if warranted by your history and physical examination.

b. Magnetic Resonace Imaging (MRI), if the Physician's evaluation indicates the presence of joint disease and an MRI is needed to assist in the diagnosis.

c. Psychosocial assessment to determine if evaluation by a Psychologist or psychiatrist is appropriate. However, comprehensive psychological inventories are not covered.

d. blood testing and urinalysis to identify blood, musculoskeletal, chemical or other abnormalities suggestive of systemic disease.

e. diagnostic injections, such as nerve blocks.

2. surgical and non-surgical treatment that contemporary medical consensus considers safe and effective. These are examples of services that the Plan may approve:

a. reversible intraoral prosthetic devices and appliances, such as removable splints.

b. Physical Therapy treatments reasonably expected to produce prompt and significant improvement.

c. steroid joint injections.

d. open surgical procedures and surgical arthroscopy, only if necessary to rehabilitate a functional deficit or impairment caused by specific joint disease that has been resistant to other medical treatment.

FF. **Therapies and/or Treatments.** Charges for the following providers:

1. Speech Therapy for services of a qualified Speech Therapist if such charges are made for Speech Therapy used for the purpose of restoring speech loss or correcting damage which:

a. is due to an Illness, other than a non-organic/functional disorder or surgery due to such Illness; or

b. follows surgery to correct a Birth Defect;

2. Physical Therapy performed by a Physician or licensed Physical Therapist. The therapist must be providing the therapy under the direction of a Physician. Charges for pool therapy, aquatic therapy and hydrotherapy are also recognized as Physical Therapy when performed by a Physical Therapist or other recognized licensed provider for Physical Therapy modalities, administered in a pool, which requires direct one-on-one patient contact. The therapist must be providing the therapy under the direction of a Physician for a condition that is Medically Necessary, Reasonable and appropriate for Physical Therapy treatment. Therapy will end when:

a. treatment goals have been reached; or

b. no substantive change is seen by the patient's condition after a reasonable period; or

c. maximum medical improvement has been reached;

3. Occupational Therapy performed by a Physician or licensed Occupational Therapist. The therapist must be providing the therapy under the direction of a Physician;

4. Respiratory therapy performed by a Physician or licensed Respiratory Therapist. The therapist must be providing the therapy under the direction of a Physician;

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

GG. **Tobacco Cessation Benefits.** Charges for specified tobacco cessation aids if you are a tobacco user. Specified tobacco cessation aids include both prescription drugs and over-the-counter (OTC) aids. Refer to prescription drug benefit section.

HH. **Transplants.** Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, except as provided by United HealthCare Insurance Company (UHIC) Transplant Benefit Policy, subject to the following conditions:

1. a concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

2. if the donor is covered under this Plan, eligible medical expenses Incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (5).

3. if the recipient is covered under this Plan, eligible medical expenses Incurred by the recipient will be considered eligible.

4. if both the donor and the recipient and covered under this Plan, eligible medical expenses Incurred by each person will be treated separately for each person.

5. the Maximum Allowable Charge of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

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

II. **Virtual Care.** Charges for Virtual Care including E-Visits, and Telehealth/Telemedicine.

JJ. **Vision.** Charges for the following vision services:

1. diagnosis and treatment of eye pathology.

2. eye surgery to cure an Illness or heal an Injury to the eye. **Note:** The Plan will not cover refractive eye surgery, such as radial keratotomy, to correct a vision impairment that can be corrected with lenses.

3. the initial lens after cataract surgery. **Note:** This does not include eyeglasses or contact lenses.

4. therapeutic contact lenses for treating an Illness or Injury, such as keratoconus.

5. the initial artificial eye to replace an eye lost because of Illness or Injury. **Note:** After this initial replacement, the Plan will not reimburse expenses for or related to artificial eyes,

KK. **Wigs.** Charges associated with full cranial hair prostheses (wigs) in the case of sudden onset baldness that is the consequence of a covered disease, Accident, or medical treatment and that is sufficiently extensive to significantly alter the patient's appearance.

LL. **Worker's Compensation.** Charges for any Injury or Illness arising from or sustained in the course of any occupation or employment for which benefits are not eligible under Worker's Compensation coverage or for which other liability insurance is not payable.

MM. **2019 Novel Coronavirus (COVID-19).** Covered Expenses associated with testing for COVID-19 include the following:

1. Diagnostic Tests. The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan.
   a. In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
      - that are approved, cleared, or authorized by the FDA (including an emergency authorization);
      - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
      - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
      - that are deemed appropriate by the Secretary of Health and Human Services.
   b. Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

c. Over-the-Counter Tests (OTC Tests). **Refer to prescription drug section for coverage.** The Plan will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any one of the following conditions:

- that are approved, cleared, or authorized by the FDA (including an emergency authorization);
- for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- that are deemed appropriate by the Secretary of Health and Human Services.

  - OTC Tests neither require pre-certification nor involve an individualized clinical assessment from a provider. The Plan will cover up to 8 OTC Tests, per Participant per 30 days. This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider. OTC Tests purchased from a Preferred Provider are covered by the Plan at the point of sale at 100% deductible waived. When the Plan is billed for a Non-Preferred Provider OTC Test, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan. If the Participant pays for a Non-Preferred Provider OTC Test, the Participant will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12.00 per OTC Test. If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost.
  - The following limitations also apply:
    - Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and
    - Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the Participant or their dependents. NOTE: The Plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the Plan may require a written attestation from the Participant describing the OTC Test, the price paid by the Participant, and the intended use (including for whom the OTC Test will be used).

2. Qualifying Coronavirus Preventive Services. The following items are covered at 100%, deductible waived, and do not require Pre-Certification.
   a. An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and

b. An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

This provision will terminate upon the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d.

The above benefits are specific to Diagnosis and treatment of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

DEDUCTIBLE REQUIREMENT

The deductible requirement applies each Plan Year to Covered Expenses shown in the Schedule. Such requirement is met as soon as Covered Expenses equal the deductible amount shown in the Schedule. Such expenses must be Incurred while covered in a period of time not more than the Deductible Accumulation Period.

The Deductible Accumulation Period begins on July 1 of each year.

If, during one Plan Year, the Covered Expenses Incurred by Participants in one family unit equals the Deductible Amount shown in the Schedule, then the deductible shall be deemed to have been met for all Participants of that family.

BENEFITS FOR COVERED EXPENSES

The amount of benefits payable is the Covered Expenses shown in the Schedule provided:

A. If a deductible requirement applies, benefits are not payable for expenses used to meet the deductible.

No benefit will be payable until the deductible has been satisfied for the year. It may be satisfied ONLY from the expenses covered by the Plan and otherwise payable had the deductible been satisfied.

CHARGES NOT COVERED

Charges not covered are those charges for:

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. Complications from an abortion shall be a Covered Expense whether or not the abortion is a Covered Expense.

2. **Acts of War.** Services and supplies in connection with Injury caused by war whether declared or not or by international armed conflict.

3. **Allergy Treatment.** Testing or treatment that the American Academy of Allergy, Asthma, and Immunology (AAAAI) considers unproven or unconventional, except as specifically provided in the Plan. These are examples of such services:

    a. Sublingual antigen drops, a technique in which antigens are administered sublingually (under the tongue) to provoke or treat allergic reactions.

    b. Provocative and neutralization testing and treatment, which involves placing allergy-producing substances under either the skin or the tongue and then "neutralizing" the symptoms with a weaker solution of the same substance.

    c. Repeated intradermal testing. Repeated testing is not covered unless information is provided that substantiates the need for continued intradermal testing according to AAAAI guidelines.

    d. Skin-test end-point titration for evaluating the effectiveness of immunotherapy.

    e. Food allergy desensitization therapy. Although testing for food allergies is covered under the Plan if it is warranted by the history and physical exam, food allergy therapy is not. The AAAAI maintains that the only proven therapy in treating food allergies is the strict elimination of the offending food.

4. **Alternative Care.** Services or interventions that, while they may be beneficial, have not been scientifically documented as safe and effective for a specific Illness or Injury. Examples include, but are not limited to, acupuncture, acupressure, guided imagery, meditation, Rolfing, reflexology, yoga, hypnosis, aromatherapy, relaxation techniques, herbal medicine, naturopathy, iridology, Ayurvedic medicine and massage therapy.

5. **Before Enrollment and After Termination.** Services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

6. **Chelation Therapy.** Charges for chelation therapy, except to treat heavy metal poisoning.

7. **Claim Filing Limit.** Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.

8. **Close Relative.** Services of any person who is a member of your immediate family or who resides in your home.

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

10. **Complications of a Non-Covered Expense.** Treatment, service or supplies due to complications of a non-covered expense, except for complications from a non-covered abortion.

11. **Confinement.** Charges for confinement in a place which is primarily a school, a place of rest, a place for the aged or a nursing home.

12. **Cosmetic Treatment/Surgery.** Cosmetic, plastic, reconstructive or restorative surgery unless such Covered Expenses are Incurred for repair of a disfigurement caused from any of the following:

    a. an accidental Injury;

    b. a Birth Defect;

    c. as the result of a covered surgical procedure.

13. **Custodial Care.** This is care made up of services and supplies that meets one of the following conditions:

    a. care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment;
    b. care that can safely and adequately be provided by persons who do not have the technical skills of a covered Health Care Professional.

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

    a. who recommends, provides or directs the care;

    b. where the care is provided;

    c. whether or not the patient can be or is being trained to care for himself or herself.

14. **Dental Care.** Except as specifically provided in the Plan, following are examples of services that are not covered:

    a. subsequent treatment to an injured tooth after the initial treatment.

    b. Orthodontia, occlusal adjustments or dental restorations unless required to repair and restore the functioning of a natural tooth that is injured.

    c. replacement of crowns, bridges, partial or full dentures or implants.

    d. implants or oral surgery for, or in connection with, implants unless needed to repair and restore the functioning of a sound, natural tooth that has been injured.

e. Orthognathic surgery unless required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment.

f. behavior modification therapy or symptomatic care such as nutritional counseling and home therapy programs.

g. any service that is directed at improving the appearance of a tooth and that does not meaningfully restore the function of an injured tooth or any tooth; for example, bleaching.

15. **Dependent Entitled to Benefits as an Employee.** Your dependent for any medical expense for which the dependent is entitled to benefits as an Employee or former Employee of the policyholder.

16. **Developmental Delays/Recreational/Educational Therapy.** Expenses and services in connection with:
    a. developmental delay
    b. recreational and educational therapy
    c. learning disabilities
    d. behavior modification therapy
    e. non-medical self-care or self-help training including any diagnostic testing
    f. music therapy
    g. health club memberships

    This exclusion will not apply to expenses related to the diabetic self-management education programs, the initial diagnosis and testing of developmental delays or if the developmental delay is caused by an Illness, disease, Injury or surgery and any pervasive development disorder not otherwise specified.

17. **Error.** 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.

18. **Experimental or Investigational.** Services that are Experimental or Investigational.

19. **Foot Care.** Charges for 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.

20. **Government Facility.** Expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government

21. **Hearing Services.** Except as specifically provided in the Plan, following are examples of services that are not covered:

    a. batteries and cords.

b. routine hearing exams except as outlined in the Preventive Care benefit

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

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

24. **Infertility.** Expenses for confinement, treatment, services or supplies given for or related to any of the following:

    a. in-vitro fertilization;

    b. embryo transfer procedures;

    c. artificial insemination.

25. **Illegal Activity.** For an 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);

26. **Maternity.** Except as specifically provided in the Plan, following are examples of services that are not covered:

    a. Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus.

    b. childbirth education or preparation courses; for example, Lamaze classes.

27. **Medically Necessary.** Services that are not Medically Necessary.

28. **Medical Marijuana.** Charges for marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.

29. **Missed Appointments.** Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.

30. **Negligence.** For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

31. **Non-Compliance.** This Plan will not pay for any charge which has been refused by another plan covering the Participant as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

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

32. **Not Covered.** That are not specifically covered under this Plan.

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

34. **Nutritional Supplement.** Total parenteral nutrition, dietary medical treatment of phenylketonuria (PKU), and amino acid-based elemental formulas.

35. **Organ Transplant.** Any expenses for which benefits are payable under the United HealthCare Insurance Company (UHIC) Certificate of Coverage are excluded from coverage under this Plan.

36. **Other Person.** For expenses actually Incurred by other persons.

37. **Personal Comfort Items.** Services or supplies which constitute personal comfort or beautification items; television or telephone use; physical fitness programs or equipment; or exercise therapy.

38. **Physician Certified Provider.** Other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease and performed by an appropriate Provider.

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

40. **Prohibited by Law.** To the extent that payment under this Plan is prohibited by law.

41. **Provider Error.** Required as a result of unreasonable provider error.

42. **Radiation/Nuclear Accident.** Any loss directly or indirectly caused by or contributed to or arising from:

    a. ionizing radiation, pollution or contamination by radioactivity from nuclear waste from the combustion of nuclear fuel; and

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

43. **Rendered.** That are not actually rendered.

44. **Self-Inflicted.** 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.

45. **Sexual Dysfunction.** Charges for any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants, and hormonal therapy, except of dysfunction due to organic disease or gender dysphoria, unless otherwise specified by the Plan.

46. **Social Worker.** Services of a Social Worker including a psychological or psychiatric Social Worker, other than for which there is a benefit available under Home Health Care Services, Hospice Care Services or the Outpatient treatment of a Mental or Nervous Disorder or Substance Abuse.

47. **Speech Therapy.** Charges for Speech Therapy, except as specifically provided in the Plan.

48. **Standard Practice.** That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA) or the Food and Drug Administration (FDA).

49. **Sterilization.** Reversal of sterilization.

50. **Subrogation.** Charges for Illnesses or injuries suffered by a Participant due to the action or inaction of any party if the Participant fails to provide information as specified in Subrogation.

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

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

51. **Temporomandibular Joint Dysfunction (TMJ) Treatment.** Except as specifically provided in the Plan, diagnostic tests that general medical consensus considers unproven or unconventional. The following are examples of such services:

    a. Electromyography (EMG) or muscle testing.

    b. Electronic jaw-tracking systems.

    c. Thermography and kinesiography.

    d. Ultrasonography.

    e. Radiography or regular dental X-rays.

    The following are examples of treatment the Plan will not cover because general medical consensus considers them unproven or unconventional:

    a. Orthodontic (use of braces) and orthognathic (use of surgery) treatment for changing the bite.

b. Occlusal adjustment or modification of a dental surface to change the bite.

c. Restorative therapy or prosthodontic treatment (use of crowns and bridges to balance the bite).

d. Ultrasonic treatment, electrogalvanic stimulation, iontophoresis, and biofeedback.

e. Transcutaneous electrical nerve stimulation (TENS).

f. Nutritional counseling and home therapy programs.

g. Services to treat chronic conditions or any conditions for which there is no reasonable expectation of a prompt and predictable improvement in your health status.

h. Services that continue after you reach the expected state of improvement, resolution, or stabilization of your health condition.

52. **Third Party Exams**. 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.

53. **Vision Services.** Except as specifically provided in the Plan, any service or supply for, or in connection with:

a. refractive eye surgery, such as radial keratotomy.

b. vision training procedures and orthoptics.

c. routine eye examinations.

d. refractions, eyeglasses, contact lenses, or fitting of eyeglasses or contact lenses.

e. non-prescription lenses.

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

55. **Weight Loss.** Except as specifically provided in the Plan, treatment, services and supplies in connection with obesity, weight loss or dietary control, unless related to Morbid Obesity (which is the lesser of 100 pounds over normal weight or twice normal weight). Specifically excluded, even if related to Morbid Obesity, are charges for bariatric surgery, including but not limited to gastric bypass, stapling, and intestinal bypass and lap banding surgery, including reversals. This exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

56. **Wigs.** Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, unless specifically provided in the Plan.

57. **Worker's Compensation.** Any Injury or Illness arising from or sustained in the course of any occupation or employment for which benefits are eligible and have been paid or will be payable under a Worker's Compensation coverage or other liability insurance.

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

PLAN ADMINISTRATION

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

Plan Administrator

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

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

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

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

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

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

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

DEFINITIONS

For the purpose of the coverage provided under this policy,

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

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

ADVERSE BENEFIT DETERMINATION shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits;
4. A termination of 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 EXPENSE(S) means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

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

ALTERNATE RECIPIENT means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

AMBULATORY SURGICAL CENTER means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures. The center must be licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

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

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

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

APPROVED CLINICAL TRIAL means a phase I, II, III or IV trial that is conducted in relation to the prevention detection, or treatment of cancer or other life-threatening disease or condition as defined under the Affordable Care Act (ACA) and that is federally funded by specified agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required)

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

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

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

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

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

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

1. it is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located;
2. it meets all of the following requirements:
    a. it is operated and equipped in accordance with any applicable state law;
    b. it is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;

c. it has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation and blood expanders;
d. it is operated under the full-time supervision of a licensed doctor of medicine (M.D.) or Registered Nurse;
e. it maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications;
f. it maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, laboratory or diagnostic tests and a postpartum summary.

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

CERTIFIED IDR ENTITY shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

CHILD means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

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

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

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

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

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

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

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

CONCURRENT CARE means ongoing care or course of treatment.

COPAY means the charge a Participant pays for certain services under the Plan. The Participant pays the Copay directly to the provider of the health care.

COVERED EXPENSE(S) 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.

CUSTODIAL CARE means care which:

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

DURABLE MEDICAL EQUIPMENT means equipment which is:

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

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

Durable Medical Equipment does not include:

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

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

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

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

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Preferred Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Participant is able to travel using non-medical transportation or non-Emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Preferred Provider.

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

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

ENROLLMENT DATE means the first day of coverage (or, if there is a Waiting Period, the first day of the Waiting Period).

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

E-VISIT means Participant initiated limited online evaluation and management health care service provided by a Physician or other qualified Health Care Professional using the internet or similar secure communications network to communicate with an established Participant patient.

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

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

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

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

a. maximum tolerated dose;
b. toxicity;
c. safety;
d. efficacy; and
e. efficacy as compared with the standard means of treatment or diagnosis.

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

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

EXPLANATION OF BENEFITS (EOB) shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ILLNESS means a covered bodily or Mental infirmity or pregnancy.

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

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable State law, and which provides any Emergency Services.

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

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

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

INTENSIVE OUTPATIENT SERVICES means programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.”

LATE ENROLLEE means a Participant who enrolls under the Plan other than during the initial enrollment period in which the individual is eligible to enroll under the Plan or during a special enrollment period.

LEAVE OF ABSENCE means a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Employer, and as provided for in the Employer’s rules, policies, procedures and practices where applicable.

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

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

MAXIMUM ALLOWABLE CHARGE shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Comprehensive Medical Coverages,") if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

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

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

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

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. it is ordered by a Physician for the diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate the Centers for Medicare and Medicaid Services (CMS) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

MEDICALLY NECESSARY LEAVE OF ABSENCE means a Leave of Absence by a Full-Time Student dependent at a postsecondary educational institution that:

1. Commences while such dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such dependent to lose student status for purposes of coverage under the terms of the Plan.

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

MENTAL OR NERVOUS DISORDER means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

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

MORBID OBESITY means either:

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

NATIONAL MEDICAL SUPPORT NOTICE (NMSN) means a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

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

NON-VARIABLE HOUR EMPLOYEE means an Employee reasonably expected at the time of hire to work 30 or more hours per week. For Employees who were covered by a group health insurance policy of the School District of Spring Valley prior to August 31, 2011, Non-Variable Hour Employee means an Employee reasonably expected to work 20 or more hours per week.

NON-EMBEDDED means a Non-Embedded deductible wherein the individual deductible is not included within the family deductible. For family coverage, the entire family deductible must be met before benefit plan coverage takes effect – by any one or a combination of family members.

NON-PREFERRED PROVIDER means any provider which does not satisfy the definition of Preferred Provider.

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

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

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

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

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

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

OTHER PLAN shall include, but is not limited to:

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

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

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

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

PARTIAL HOSPITALIZATION means medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

PARTICIPANT means any Employee, dependent, retired Employees, or individual that is covered under the Plan through COBRA continuation, who has been enrolled and approved for coverage under the Plan.

PARTICIPATING HEALTH CARE FACILITY shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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

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

PHYSICIAN ASSISTANT means a Health Care Professional who diagnoses Illness, develops and manages treatment plans, and prescribes medications in collaboration with or under the supervision of a Physician, dependent on state law.

PLAN YEAR means a period from July 1 through the following June 30, both dates inclusive.

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

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

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

PREFERRED PROVIDER shall mean the facilities, providers and suppliers who have by contract via a medical provider network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the network's providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Preferred Provider network (PPO) will be identified on the Participant's identification card. For prescription drugs available through the prescription drug and/or specialty drug program (as applicable), Preferred Provider means the prescription drug card program or specialty drug program and does not include any other network of providers with which the Plan contracts.

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

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

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

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

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

PSYCHOLOGIST means such person:

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan.

QUALIFYING PAYMENT AMOUNT means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Claims Administrator (if calculated by the Claims Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

RECOGNIZED AMOUNT shall mean, except for Non-Preferred Provider air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable State law. If no such amounts are available or applicable and for Non-Preferred Provider air ambulance services generally, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

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

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

RESIDENTIAL TREATMENT FACILITY means a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

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

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

1. it is operated under the applicable licensing and other laws;
2. it is under the supervision of a licensed Physician or Registered Nurse (R.N.) who is devoting full-time to supervision;

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

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

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

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

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

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

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

SUBSTANCE ABUSE and/or SUBSTANCE USE DISORDER means any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

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

TELEHEALTH/TELEMEDICINE means professional evaluation and medical management services provided to patients through the use of digital tools such as remote physiologic monitoring, remote evaluation of images and/or video, virtual check in, interprofessional telephone/internet consultations, patient telephone evaluation and management services provided by a Physician or other qualified Healthcare Professional and interactive audio and video communications.

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

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

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

VIRTUAL CARE means professional evaluation and medical management services provided to patients through e-mail, telephone or webcam to communicate in real-time. Virtual Care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which Physicians respond with substantive medical advice. It does not include communication for reporting normal laboratory or test results or calling in or sending a prescription to a pharmacy.

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

WELL CHILD CARE means medical treatment, services or supplies rendered to a Child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan with the following exception: Coordination does not apply to prescription drug benefits available under a prescription drug card.

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

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

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

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

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

Claim Determination Period
"Claim Determination Period" shall mean each Plan Year.

Effect on Benefits:

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

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

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

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

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

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

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

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

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

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

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

PROVISION FOR COORDINATION OF BENEFITS WITH MEDICARE

DEFINITIONS

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

2. "Fully Covered Person" means any person who is both eligible for and enrolled in ("entitled") Medicare coverage.

3. "Full Medicare Coverage" means coverage for all of the benefits provided under Medicare with the exception of Medicare Part D, including any benefits provided on an optional basis.

EFFECTS ON BENEFITS

Coordination of benefits does not apply to Medicare Part D.

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

Except that:

For working Employees age 65 and older who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage may provide supplemental benefits for those expenses not paid by this Plan. If the working Employee's Spouse is also enrolled in this Plan, this provision would apply to the Spouse during the period of time both the Employee and the Spouse are age 65 and older. If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement 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.

The Participant has the right to voluntarily enroll in Medicare due to an ESRD diagnosis and has the right not to be requested or encouraged to disenroll from this Plan, except in circumstances specified in federal law. The Plan will not reduce benefits where federal law requires that benefits are determined without regard to benefits available under Medicare.

GENERAL INFORMATION

Unless otherwise stated, benefits are payable only for covered losses which occur while the insurance is in force.

The benefits do not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of coverage. It does not pay in addition to Worker's Compensation.

CLAIMS INFORMATION AND FORMS

You may get claim forms which relate to your benefits from your Plan Representative.

All bills must be fully itemized on the provider's billing or stationary. The group's plan number, the insured Employee's social security number, the patient's full name and the date(s), type(s) and charge(s) for each service must be on the billing. Cancelled checks, paid receipts and balance due statements are not acceptable.

The Administrator has the right to pay any benefits to the provider of service. This will be done unless the bill has been marked paid.

DEFINITION OF WORK ON A FULL-TIME BASIS

As used in this Plan, "work on a full-time basis" means the Employee must work for his Employer at his usual place of work or such other place or places as required by his Employer in the course of work for the full number of hours and full rate of pay, as set by the employment practices of his Employer. Employees may be scheduled to work for the school year (nine months) or for the Plan Year (twelve months). In no event shall the amount of time worked be less than 30 hours per week or 130 hours per month for the school year or the Plan Year if the Employee is a Non-Variable Hour Employee. If the Employee is a Variable Hour Employee, in no event shall the amount of time worked average less than 30 hours per week or 130 hours per month during a completed Measurement Period. A Variable Hour Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an Employee in accordance with the Affordable Care Act (as amended).

Employees who were covered by a group health insurance policy of the School District of Spring Valley prior to August 31, 2011 are eligible for coverage under this Plan under the same terms and conditions as previously applied if they continue to meet the previous eligibility standards. These Employees may be scheduled to work for the school year (nine months) or for the Plan Year (twelve months). In no event shall the amount of time worked be less than 20 hours per week or 86 hours per month for the school year or the Plan Year if the Employee is a Non-Variable Hour Employee. If the Employee is a Variable Hour Employee, in no event shall the amount of time worked average less than 20 hours per week or 86 hours per month during a completed Measurement Period. A Variable Hour Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an Employee in accordance with the Affordable Care Act (as amended).

An Employee shall be deemed working on a full-time basis if the Employee is absent from work due to a health factor as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee shall be deemed working on a full-time basis on any Employer-approved holiday, vacation, or paid leave on which the Employee is not totally disabled provided that the Employee was working on a full-time basis on his last regularly scheduled working day. In no event will an Employee be considered working on a full-time basis if he has effectively terminated employment.

ELIGIBILITY

Employees who were covered by a group health insurance policy of the School District of Spring Valley on August 31, 2011 are eligible for coverage under this Plan under the same terms and conditions as previously applied if they continue to meet the previous eligibility standards.

All Employees of School District of Spring Valley (or an Associated Company included for coverage in the policy contract) are eligible if:

A. they are doing work on a full-time basis;
B. they are not temporary Employees;

For Non-Variable Hour Employees, eligibility starts the first of the month following the start date of employment.

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

Should an Ongoing Employee change their job status from part-time to full-time or full-time to part-time during a Measurement Period, the Employee will be eligible for coverage the first of the month following the change in job status.

Each Employee who was covered under the prior Plan, if any, will be eligible on the effective date of this Plan. Any service Waiting Period or portion thereof satisfied under the prior Plan, if any, will be applied toward satisfaction of the service Waiting Period of this Plan.

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

EFFECTIVE DATE OF EMPLOYEE

A. Your coverage will be made effective on the date you are eligible if you fill out the application and the card which provides for deductions (if applicable) on or before that date; or

B. If you make application within thirty-one days after the date on which you become eligible, the coverage will be made effective the date you apply and authorize deductions for coverage subject to the Open or Special Enrollment Periods section.

DEPENDENT ELIGIBILITY

Eligible dependents are the persons shown below who are not eligible as Employees:

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

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

C. an Employee's Child who is less than 26 years of age; regardless of financial dependency, residency, student status, employment, marital status or any combination of these factors;

D. an Employee's Child who satisfies all of the following criteria:
   1. a Full-Time Student regardless of age;
   2. was under the age of 27 when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while a Full-Time Student at an institution of higher education;

E. an Employee's unmarried Child determined to be an Incapacitated Person who is over the age limit for dependent coverage on the effective date of the policy if:
   1. such Child was covered under the policyholder's prior plan on the day before the effective date of the policy; and
   2. such Child would qualify to have his coverage continued according to the terms of Item (C) of the "Termination of Dependent Coverage" provision;

F. an Employee's Child indicated in a Qualified Medical Child Support Order, as required under the Omnibus Budget Reconciliation Act of 1993, as amended;

G. an Employee's grandchild provided that the grandchild meets the definition of Child. For example:
   1. a lawfully adopted Child or a Child placed with a covered Employee in anticipation of adoption;
   2. a Child for whom the Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO); or
   3. a Child for whom the Employee has obtained legal guardianship.

The coverage of such Child shall terminate automatically on the latest of the dates shown in the "Termination of Dependent Coverage" provision.

No person may be covered as a dependent of more than one Employee.

EFFECTIVE DATE FOR DEPENDENT COVERAGE

Dependent coverage cannot become effective prior to the date Employee coverage is effective. Dependent coverage shall be effective with respect to each eligible dependent on the date shown below.

A. if contributions are not required, dependent coverage shall be effective on the date the Employee is eligible for dependent coverage, if the Employee makes written application within 31 days;

B. if contributions are required, dependent coverage shall be effective, if the Employee makes written application within 31 days, on the earliest of:
   1. the date the Employee is eligible for dependent coverage if he agrees to make contributions before such date;
   2. the date the Employee agrees to make contributions if such date is within 31 days after he is eligible for dependent coverage;

C. the date indicated in a Qualified Medical Child Support Order, as required under the Omnibus Budget Reconciliation Act of 1993, if the Employee makes written application for the eligible dependent Child;

D. if the Employee makes written application for the eligible dependent more than 31 days after the date on which a dependent became eligible for dependent coverage, such dependent will be a Late Enrollee and will not be covered under this Plan except as provided in the Open or Special Enrollment Periods section;

E. if dependent coverage ends because the Employee does not make contributions, dependent coverage will be restored only as stated in the Open or Special Enrollment Periods section.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will provide for immediate enrollment and benefits to the Child or children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or children reside with the Participant, provided the Child or children are not already enrolled as an eligible dependent as described in this Plan. If a QMCSO is issued, then the Child or children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of “National Medical Support Notice.”
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan’s default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
   a. Whether the Child is covered under the Plan.
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
   a. Be in writing.
   b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.

c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

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:
1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. 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 related 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 related to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting condition limitations. Offering reduced premiums or other rewards for providing Genetic Information would be impermissible underwriting.

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

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

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

OPEN OR SPECIAL ENROLLMENT PERIODS

Open Enrollment Period

You are a Late Enrollee under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your dependent is a Late Enrollee if you elect not to cover a dependent and then later want coverage for that dependent. A Late Enrollee will be eligible to enroll for coverage during the Open Enrollment Period, of May 1 through June 30 to become effective July 1. The Waiting Period will be waived.

An enrollment is "late" if it is not made on a "timely basis" or during a special enrollment period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

Special Enrollment Periods

The Enrollment Date for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

A. Individual losing other coverage. An Employee or dependent who is eligible, but not enrolled in this Plan, may enroll if either of the following conditions are met:

1. (a) The Employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual and such coverage is no longer available to the Employee or dependent.
   (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
2. The coverage of the Employee or dependent who has lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or Employer contributions toward the coverage were terminated.

An Employee must request enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, as described above. Notwithstanding the foregoing, if the Employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

B. The following conditions will be applied in accordance with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

1. Employees and dependents who are eligible, but not enrolled for coverage under the Plan have the opportunity to enroll when the Employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminates as a result of loss of eligibility and the Employee requests coverage under the Plan not later than 60 days after the date of termination.
2. Employees and dependents who are eligible, but not enrolled for coverage under the Plan have the opportunity to enroll when the Employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the Employee requests coverage under the Plan within 60 days after the date the Employee or dependent is determined eligible for the premium assistance.

C. Dependent beneficiaries. If:

1. The Employee is a Participant under this Plan (or has met the Waiting Period applicable to becoming a Participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous period), and
2. A person becomes a dependent through marriage, legal guardianship, a foster Child being placed with the Employee, birth, adoption or placement for adoption

then the dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered dependent of the covered Employee. In the case of birth or adoption of a Child, the Spouse of the covered Employee may be enrolled as a dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The dependent special enrollment period is a period of 30 days and begins on the date of marriage or on the date established by the court order as the date on which you began guardianship.

The dependent special enrollment period is a period of 60 days and begins on the date of legal guardianship, a foster Child being placed with the Employee, birth, adoption or placement for adoption.

The coverage of the dependents enrollment in the special enrollment period will become effective:

1. in the case of marriage, the date of the marriage;
2. 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;
3. 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;
4. in the case of a dependent's birth, as of the date of birth; or
5. in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

TERMINATION OF EMPLOYEE COVERAGE

Coverage shall terminate on the latest of the following dates:

A. the date this Plan terminates for any reason;
B. at the end of the plan year or on the date of a qualifying event upon employee request;
C. the date on which you enter the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces;
D. for a Non-Variable Hour Employee, the date on which you cease to be a member of the eligible class of Employees specified by your Employer for coverage under this Plan. For example, you have a change in your job duties or in the number of hours worked that renders you ineligible for coverage, unless the Employee is required to pay for all or part of his coverage and contributions have been made. Termination will then be the end of the period for which the last contribution was made;
E. for a Variable Hour Employee, the end of the month following the end of the Stability Period, if the Employee failed to qualify during the previous Measurement Period, unless the Employee is required to pay for all or part of his coverage and contributions have been made. Termination will then be the end of the period for which the last contribution was made;
F. the date on which your occupational group ceases to be part of the eligible class of Employees specified by your Employer as being part of an insured group;
G. the last day of the month in which you become ineligible because of the termination of your employment, whether voluntary or involuntary;
H. the date on which you fail to comply with any provision of this Plan;
I. the date of your death
J. the date the retired Employee turns age 65 or Medicare eligible.

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 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).

TERMINATION OF DEPENDENT COVERAGE

Dependent coverage shall end on the latest of:

A. the date the Employee's coverage ends for any reason, except for the Employee's death. If the Employee dies, coverage for their dependents will end on the last day of the month of their death. (Note that continuation coverage options are available to your covered dependents in this event.), unless the Employee is required to pay for all or part of the dependents coverage and contributions have been made. Termination will then be the end of the period for which the last contribution was made;

B. as to any one dependent other than a dependent Child, the last day of the month such dependent ceases to be eligible;

C. as to any one dependent Child, the last day of the month such dependent ceases to be eligible. If a covered Child is determined to be an Incapacitated Person the coverage for such Child may be continued beyond the age at which such coverage would automatically terminate if:

   1. the dependent is unmarried; and
   2. is chiefly dependent on the Employee for support and maintenance; and
   3. is incapable of self-sustaining employment due to intellectual disability or permanent physical handicap;
   4. the first proof of Incapacitated Person is furnished to the company within 31 days after the date such Child reaches the limiting age. Such proof shall be without cost to the company;

   Such coverage may be continued as long as the Employee remains eligible under the Plan and the dependent remains unmarried, an Incapacitated Person and dependent upon the Employee. Incapacitated Person does not include a dependent who is temporarily unable to attend school due to Accident or Illness.

E. the date on which your dependent enters the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces;

F. as to any benefit, the date such benefit ends.

G. the date the Dependent turns age 65 or Medicare eligible.

FULL-TIME STUDENT STATUS

A person continues to be a Full-Time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-Time Student immediately following the period of vacation, the Full-Time Student designation will end on the last day of the calendar month in which the person was enrolled at the institution on a full-time basis.

COVERAGE CONTINUATION OPTION FOR RETIRED EMPLOYEES

If you retire at age 55 or older while you are covered by this Plan as an active Employee, you have the option of continuing coverage under the same conditions as before your retirement. You may continue coverage under this option as long as **both** of the following apply:

A. The Plan receives the required premiums on time.

B. The Plan continues to insure the active Employees in the occupational group within the eligible class of Employees from which you retired.

The coverage you are eligible to continue will be the same health plan as that in effect for the active Employees in the occupational group within the eligible class of Employees from which you retired.

Example No. 1: You are a librarian covered under this Plan at the time you retire at age 62. You decide to continue your coverage under this provision. Sometime after you retire, the librarians that are actively working for your former Employer move to a different health plan. Because your coverage and benefits are the same as those in the occupational group to which you belonged before retiring, you will also be moved to the new health plan. You may, of course, decide that you no longer want to continue coverage because of the change and terminate your health plan.

Example No. 2: You are a teacher covered under this Plan at the time you retire at age 55, and you decide to continue your coverage under this provision. Later, the teachers that are actively working for your former employer move to a health plan with a different insurer. Because we no longer insure the active Employees in the occupational group to which you belonged at the time you retired, you will lose your health plan coverage under this provision. Note that if you are till within the continuation period provided by state and federal law, you may be able to finish your period of continuation coverage under the Employer's successor insurer.

If you do not choose to continue coverage under this option at the time you retire, you cannot do so later. In that case, continued coverage for you and your covered dependents will be limited to that required by state and federal law. Your rights and obligations under those laws are described in section under "COBRA Continuation of Coverage."

If you continue coverage under this option, you will be responsible for paying the required premiums for coverage. Your premium will be based on the group rates in effect for the Employer on each date that premium is due. Your premium will depend on the rate classification to which you belong. You may find the rate classifications and corresponding premium amounts on the Employer's Rate Summary.

If you exercise this option, the following rules will apply to your dependents:

A. If you marry, you may obtain coverage for any new eligible dependents and may change from single to family coverage, but only if the Plan receives the required enrollment form within 30 days of the date of your marriage.

B. If you divorce, your former Spouse will have the continuation coverage rights required by state and federal law.

C. Your dependent children are eligible for coverage as long as they qualify as dependents. When they no longer qualify, they will have the continuation coverage rights required by state and federal law.

WHAT IT COSTS

You will be required to pay the whole cost to the Plan for your continuation coverage. Where the Plan's benefits are provided by insurance, your cost will be the amount of the insurance premium (including any part formerly paid by the Employer) plus an administrative expense fee. Where the Plan pays it benefits directly (without insurance), your cost will not exceed the Plan's Reasonable estimate of its expense for the benefits of the same class of Employees or dependents who are not on continuation.

COVERAGE CONTINUATION RIGHTS OF SURVIVING DEPENDENTS

If you are covered by this Plan at the time of your death, your surviving covered dependents have the right to continue the coverage they had before your death, as described below. This right is available as long as the Plan receives the required premiums and continues to insure the active Employees in the occupational group within the eligible class of Employees to which you belonged before your death. If your surviving dependent choose to continue coverage, they will be responsible for paying the required premiums for coverage. The premium rate will be the same as the rate in effect; on each date that premium is due, for the eligible class of Employees to which you belonged at the time of your death.

Survivors of Covered Employees Who are Under Age 55

If you are under age 55 when you die, your dependents have the continuation coverage rights required by state and federal law.

Survivors of Covered Employees Who are Age 55 or Older

If you are covered by this Plan as an active Employee and are age 55 or older when you die, your dependent have the right to continue coverage, and that right will not be limited to their legal rights to continuation coverage.

Your Spouse may continue coverage for as long as desired if **both** of the following apply:

A. The Plan receives the required premiums on time.

B. The Plan continues to insure the active Employees in the occupational group within the eligible class of Employees to which you belonged at the time of your death.

Your dependent children are eligible for coverage if your surviving Spouse continues family coverage and they continue to qualify as dependent under this Plan. The coverage your dependent are eligible to continue will be the same health plan as that in effect for the active Employees in the occupational group within the eligible class of Employees to which you belonged at the time of your death. See Examples 1 and 2 under “Coverage Continuation Option for Retired Employees.”

If, during the period of continuation coverage required by law, your surviving Spouse obtains coverage for a new Spouse or children who qualify as dependents, coverage for these new dependents will be effective only for your Spouse’s remaining period of continuation coverage required by state and federal law. These new dependents have no rights to continue coverage after your surviving Spouse ceases to be eligible for coverage or they cease to qualify as dependents under this Plan.

Rights of Surviving Dependent Children

If your surviving covered dependent Child chooses single coverage under this Plan at the time of your death, continuation coverage rights for that Child will be limited to those required by state and federal law.

WHAT IT COSTS

You will be required to pay the whole cost to the Plan for your continuation coverage. Where the Plan's benefits are provided by insurance, your cost will be the amount of the insurance premium (including any part formerly paid by the Employer) plus an administrative expense fee. Where the Plan pays it benefits directly (without insurance), your cost will not exceed the Plan's Reasonable estimate of its expense for the benefits of the same class of Employees or dependents who are not on continuation.

EMPLOYER CONTINUATION COVERAGE

However, if an Employee is not working on a full-time basis as a result of an Employer approved Disability leave, he or she will continue to be eligible to receive full-time Employee coverage under the Plan subject to the following:

A. not beyond 90 days after the date coverage would have normally terminated;
B. premium must be paid by the first of each month;
C. unless the Employee returns to full-time work prior to or immediately following the approved Disability leave, the Employee will become eligible for COBRA.

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.

CONTINUATION DURING COBRA

Our medical and prescription drug benefit plan includes the health coverage continuation rights required by federal law. If you have such coverage under our benefit plan and if that coverage ends for a reason listed below, you may be able to continue the coverage under our benefit plan for a certain period. This section is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This section is intended to reflect the law and does not grant or take away any rights under the law.

In addition to COBRA rights, you have similar continuation rights under Wisconsin law. You may also have additional continuation rights granted by this Plan in certain situations such as retirement, total Disability, or the death of the covered Employee. (See "Coverage Continuation Option for Retired Employees," "Coverage Continuation Rights of Surviving dependents," and "The Onset of Disability While Covered by this Plan,".) If you elect continuation coverage, your COBRA, state continuation and Plan provided continuation coverage will all run concurrently, not consecutively.

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

QUALIFYING EVENTS

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The Spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or legally separated from his or her Spouse.

Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or legally separated.
6. The Child stops being eligible for coverage under the Plan as a dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed to be the Qualifying Event. The retired Employee's dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

EMPLOYER NOTICE OF QUALIFYING EVENTS

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

WHAT YOU HAVE TO DO

You must advise the Plan in the event of a divorce or legal separation and in the event a Child is no longer qualified as a dependent. You must do this within 60 days of such an event or within 60 days of loss of coverage, if later. Whenever you become qualified for continuation coverage, for reasons listed in this COBRA Section, the Plan will notify you of the premium required.
If you decide to take continuation coverage, you will have 60 days to notify the Plan from the later of:

A. the date your coverage would terminate if there were no continuation, or
B. the date the Plan's notice referred to above is sent to you.

You then have 45 days to pay all of the necessary premium to continue your coverage from the date it would otherwise end under the Plan.

WHO CAN PROVIDE THE NOTICE

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

REQUIRED CONTENTS OF THE NOTICE

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, cessation of dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
    a. In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and dependent Child or children covered under the Plan, date of divorce and a copy of the decree of divorce.
    b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of Spouse and dependent Child or children covered under the Plan.
    c. In the case of a Qualifying Event that is a dependent Child’s cessation of dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible dependent (for example, attained limiting age).
    d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and dependent Child or children covered under the Plan.

e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

WHAT COVERAGE IS CONTINUED

These continuation rights apply only to Hospital, surgical and medical coverage, plus dental, vision, prescription drug and Hospital indemnity benefits, if part of your Plan. Any other type of coverage provided by our medical and prescription drug benefit plan is not included in these continuation rights.

Your continued health coverage will be the same as the coverage provided by the Plan for Employees or dependents in the same class who are not on continuation.

HOW LONG COVERAGE MAY CONTINUE

Coverage continued upon termination of your employment or a reduction in your work hours is limited to 18 months. Otherwise, continuation coverage is limited to 36 months. Within those limits, coverage will end on any earlier date that:

A. the Plan no longer provides any health coverage for Employees, or

B. you do not pay a premium for your continued coverage by the date it is due or within the grace period, or

C. the Participant is covered under another group health plan, or

D. you become entitled to (covered by) Medicare.

The qualified beneficiary must notify the Plan within 30 days after he becomes covered by another group health plan or entitled to Medicare.

COBRA allows a qualified beneficiary, who is determined to be disabled for Social Security purposes during the first 60 days of continuation coverage, to continue COBRA coverage for a total of 29 months (rather than 18 months).

In order to extend the coverage period, the qualified beneficiary must provide a copy of the Social Security Disability determination notice within 60 days of the date of such notice. The extended coverage may be discontinued in the month that begins more than 30 days after Social Security's final determination that the Disability has ended; again, the qualified beneficiary is responsible for notifying the Plan Administrator of this final determination.

While your coverage is continued, any conversion privilege provided by the Plan will not be available. When your continuation coverage ends, any conversion privilege may be exercised, if the Plan provides a conversion privilege, subject to all the rules that would apply if the event that qualifies you for conversion has occurred on the day your continuation ends.

WHAT IT COSTS

You will be required to pay the whole cost to the Plan of your continuation coverage. Where the Plan's benefits are provided by insurance, your cost will be the amount of the insurance premium (including any part formerly paid by the Employer) plus an administrative expense fee. Where the Plan pays its benefits directly (without insurance), your cost will not exceed the Plan's Reasonable estimate of its expense for the benefits of the same class of Employees or dependents who are not on continuation.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) – CONTINUATION PROVISION

Under the Act, if a person’s health plan coverage would terminate because of an absence due to military service, the person (and their eligible dependents) may elect to continue the health plan coverage after the absence begins for the maximum allowable period as stated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

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.

HEALTH CLAIM PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Pre-Service Urgent Care Claims:

  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

- If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.

- The Participant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:

  The Plan's receipt of the specified information; or

  The end of the period afforded the Participant to provide the information.

- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-Service Non-Urgent Care Claims:

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

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

- Concurrent Claims:

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

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

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

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

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

- Post-Service Claims:

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

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

- Extensions

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

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

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

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

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

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

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

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

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

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes.

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

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

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

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

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

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

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

- Participants a 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe;;

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

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

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

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

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

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

- If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim;
- That a Participant will be provided, free of charge: (a) Reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Benefit Plan Administrators; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

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

Requirements for First Level Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

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

For Post-Service Claims. To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

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

It shall be the responsibility of the Participant or Authorized Representative to submit an appeal under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Participant;
- The Employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the Claim for Benefits.
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

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

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

- Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-Service Non-Urgent Care Claims: Within a Reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-Service Claims: Within a Reasonable period of time, but not later than 30 days after receipt of the appeal.

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

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

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

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

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

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

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

- A description of the Plan's review procedures and the time limits applicable to the procedures.

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

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

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

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

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

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

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

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

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Pre-Service Claim, Post-Service Claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires two levels of appeal for Pre-Service and for Post-Service Claims 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 above-outlined submission and response guidelines.

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

External Review Process

A. Scope

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

2. The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, 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; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
    (b) An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
    (c) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

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

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

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

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

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

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

C. Expedited external review

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

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

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in 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 in paragraph A.3 above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

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

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

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

Assignments
For this purpose, the term “Assignment of Benefits” (or “AOB”) is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less deductible, Copays and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider’s rights to receive Plan benefits are equal to those of the Participant and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an AOB and deductibles, Copays, and coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. 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 Participant, the Plan will 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 may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

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. A medical provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Limitation of Action
A Participant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within 3 years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

AMENDMENT AND TERMINATION

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

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

GENERAL PROVISIONS

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

Agency. Neither the Plan Administrator nor the Claims Administrator is the agent of the other under this Plan for any purpose.

Binding Arbitration. 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.

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

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

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

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

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.

Gender and Number. When used in this Plan, any use of masculine pronouns includes the feminine, any use of the singular includes the plural and vice versa.

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

Indemnification.

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

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

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

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

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

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

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.

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.

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 any applicable State law(s).

SUBROGATION/REIMBURSEMENT

Payment Condition

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

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

3. In the event a Participant(s) settles, recovers or is reimbursed by any coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. 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. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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

Subrogation

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

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

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

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

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and 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 and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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 or 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 or 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 or 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.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

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 incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
    g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    h. 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.
    i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    j. 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.
    k. 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, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, 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 with respect to this provision. 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA)

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him or her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

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 the Plan's Notice of Privacy Practices are available by calling the Privacy Officer.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

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.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose Genetic Information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. 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.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him or 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 or her who are involved in his or her care or payment for his or 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 or 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. Right to Receive Notice of Privacy Practices: 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 or 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 years prior to his or 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 or her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or 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 30 days (in some cases, the Plan can request a 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 or 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 or she does not provide a reason for the request.
7. 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.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

School District of Spring Valley
S1450 CTH CC
P.O. Box 249
Spring Valley, WI 54767
Phone: (715) 778-5551
Fax: (715) 778-4761
Website: www.springvalley.k12.wi.us

Additional Contact Information for HIPAA Questions:

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

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

1. **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
2. **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. 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.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    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.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. “Summary health information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

CERTIFICATE OF CORPORATE RESOLUTION

The undersigned [Title] of School District of Spring Valley (the Corporation) hereby certifies that the following resolutions were duly adopted by the board of directors of the Corporation on _____ [Date], and that such resolutions have not been modified or rescinded as of the date hereof;

RESOLVED, that Amendment Number 17 to the School District of Spring Valley Medical and Prescription Drug Benefit Plan effective July 1, 2022 presented to this meeting is hereby approved and adopted and that the proper officers of the Corporation are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the amendment.

RESOLVED, that the proper officers of the Corporation shall act as soon as possible to notify employees of the Corporation of the adoption of this Amendment Number 17 to the School District of Spring Valley Medical and Prescription Drug Benefit Plan by delivering to each employee a copy of the summary description of the changes to the Plan in the form of the Summary Plan Description – Material Modification.

The undersigned further certifies that attached hereto are true copies of Amendment Number 17 to the School District of Spring Valley Medical and Prescription Drug Benefit Plan and Summary Plan Description – Material Modifications approved and adopted in the foregoing resolutions.

_____

[Title]

Date: _____