SUMMARY OF MATERIAL MODIFICATIONS
TO THE
VITERBO UNIVERSITY
EMPLOYEE BENEFIT PLAN

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Viterbo University Employee Benefit Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes and please attach this SMM to the front of your SPD.

The following changes to the plan have been approved and are effective May 1, 2017:

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

2. **Plan Document** – amended for clarification.

IMPORTANT MESSAGE

It is important that ANY CHANGE OF ELIGIBILITY for You and/or any of Your eligible Dependents be reported to Your Employer, as soon as possible.

Changes of eligibility include:

- Marriage or divorce
- Death of any Dependent
- Birth of a child
- Legal guardianship of a child
- Adoption or placement for adoption of a child
- Dependent child reaching the limiting age
- IRS ineligible Dependent child
- Total Disability
- Retirement
- Change of address
- Medicare eligibility

For specific details regarding eligibility/enrollment, termination and continuation of coverage, refer to SECTION 3 - ELIGIBILITY of this Summary Plan Description.

3. (Section 1) **PPO Provisions** – amended to remove reference to Gundersen Lutheran network.

HOW TO SELECT A PROVIDER

Your Plan Administrator may contract one or more PPO's to provide services to this Plan in the areas where it has Covered Persons. The PPO Network that is applicable to You is shown on Your medical ID card. A directory of the participating Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in Your PPO Network will be available at no cost when Your coverage becomes effective. The provider directory is a separate document from this Plan and is subject to change. To confirm that Your Hospital, Qualified Treatment Facility, Qualified Practitioner and other provider is a current participant in Your PPO Network, You must call the number listed on Your medical ID card.

If You elect the Health Tradition (Franciscan Skemp) network, services at Mayo Clinic may be payable at the Preferred Provider level if a prior referral has been approved by the PPO Network. Your Qualified Practitioner must initiate the formal referral process **before** services are provided at Mayo Clinic. You will receive a formal, written approval from the Plan or PPO Network. This written approval must be received **before** services are provided at Mayo Clinic. In the absence of a formal, written approval, all claims at Mayo Clinic will be paid at the non-Preferred Provider level.

If You are traveling or need Emergency care and are unable to access care from Your PPO Provider, benefits will be paid at the non-Preferred Provider level.

4. (Section 1) **Schedule of Benefits** – amended deductible, maximum out-of-pocket, and in-network coinsurance amounts.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
CONTRACT YEAR DEDUCTIBLE		
Individual	$500	$500
Family (Embedded)	$1,000	$1,000
MAXIMUM OUT-OF-POCKET LIMIT PER CONTRACT YEAR		
Individual	$1,000	$1,375
Family (Embedded)	$2,000	$2,750
After the deductible has been satisfied, allowable charges will be paid at 80% or 65% until the maximum out-of-pocket limit expense amount is met. Allowable charges from Preferred Providers will be paid at 80%. Allowable charges from all other qualified providers will be paid at 65%. Once the maximum out-of-pocket expense amount is met, the Plan will then pay 100**%** of all allowable charges.		

5. (Section 1) **Schedule of Benefits** – amended for clarification.

Pre-admission certification is required on Inpatient confinements, and Outpatient pre-certification (CMC/AHH only) is required on Outpatient chemotherapy/radiation therapy and dialysis from certain providers. See section ***"Utilization Review Plan"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, non-compliance penalties will apply.

6. (Section 1) **Schedule of Benefits** – amended in-network coinsurance amounts and added travel immunizations to preventive care section for clarification.

Acupuncture/Acupressure	80% after Deductible	65% after Deductible
Ambulance Services	80% after PPO Deductible	
Autism Spectrum Disorder Treatment Contract Year benefit is limited to the annual intensive level and non-intensive level specified by state law statute 632.895. These amounts change each year based on the Consumer Price Index.	80% after Deductible	65% after Deductible

Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care. Routine/Maintenance Care is **not** covered by the Plan.	50% Deductible waived	
Convalescent Nursing Home	80% after Deductible	65% after Deductible
Contract Year maximum benefit	30 days	
Custom-Molded Orthotics	80% after Deductible	65% after Deductible
Durable Medical Equipment	80% after Deductible	65% after Deductible
Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses. (Copayment waived if admitted on Inpatient basis within 24 hours for same condition.)	$100 Copayment, then 80% after PPO Deductible	
Express/Retail Walk-In Clinic Care Includes qualified practitioner charges, drugs, vials, injections, minor surgery, surgical supplies and x-ray and laboratory tests.	$25 Copayment, then 100% Deductible waived	
Home Health Care	80% after Deductible	65% after Deductible
Contract Year maximum benefit	40 visits	
Hospice	80% after Deductible	65% after Deductible
Hospital Services Inpatient/Outpatient	80% after Deductible	65% after Deductible
Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine	80% after Deductible	65% after Deductible
Mental/Nervous Conditions and/or Substance Abuse Inpatient/Outpatient Treatment	80% after Deductible	65% after Deductible
Oral Surgery, Temporomandibular Joint Disorder Services and other Dental Services Refer to Covered Expenses section for list of eligible services.	80% after Deductible	65% after Deductible
Physician/Qualified Practitioner/Clinic Office Visit other than for Preventive Care Includes office visit charge only.	80% after Deductible	65% after Deductible
Physician/Qualified Practitioner Fees for Surgical and Medical Services	80% after Deductible	65% after Deductible
Pre-Admission Testing	80% after Deductible	65% after Deductible
Pregnancy/Maternity Services Maternity charges not included under the Preventive Services benefit.	80% after Deductible	65% after Deductible

Preventive Care Services Preventive services included under Healthcare Reform. Ages 5 and under Ages 6 and over *To comply with statutes and regulations, preventive services are outlined in the Covered Expenses section in their entirety.*	 100% Deductible waived 100% Deductible waived	 65% after Deductible 65% after Deductible up to $700 maximum benefit per Contract Year (maximum includes all non-Preferred Provider preventive)
Preventive Care Services Preventive services not included under Healthcare Reform. Immunizations for the purpose of travel Ages 5 and under Ages 6 and over *See the Covered Expenses section for these services outlined in their entirety.*	 80% after Deductible 100% Deductible waived 100% Deductible waived	 65% after Deductible 65% after Deductible 65% after Deductible up to $700 maximum benefit per Contract Year (maximum includes all non-Preferred Provider preventive)
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. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to be receiving Preventive Care for that condition.		
Preventive Care Services Breast pump	100% Deductible waived	65% after Deductible up to $700 maximum benefit per Contract Year (maximum includes all non-Preferred Provider preventive)
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		
Therapy Services Physical , Speech, and Occupational Therapy	80% after Deductible	65% after Deductible
Transplants	80% after Deductible	65% after Deductible
Urgent Care	80% after Deductible	65% after Deductible
Virtual Care	80% after Deductible	Not Covered
X-ray, Laboratory and Pathology Services other than for Preventive Care	80% after Deductible	65% after Deductible
All Other Covered Expenses	80% after Deductible	65% after Deductible

7. (Section 1) **Schedule of Benefits** – <u>amended</u> prescription drug copays.

	Drug Card – Retail (Copayment per 34-day supply)	**Mail Service** (Copayment per 90-day supply)
Generic (Tier 1)	$15.00 Copayment	$37.50 Copayment
Brand (Tier 2)	$35.00 Copayment	$87.50 Copayment
Brand When Generic Available (Tier 3)	$50.00 Copayment	$125.00 Copayment

8. (Section 1) **How to File a Medical Claim** – added for clarification.

BALANCE BILLING

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

In addition, with respect to services rendered by a Preferred Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person 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 Covered Person is responsible for any applicable payment of coinsurances, deductibles and out-of-pocket maximums and may be billed for any or all of these.

9. (Section 1) **Utilization Review Plan** – amended "Custom Medical Care" to "CMC (Custom Medical Care)/AHH (American Health Holding)" and "CMC/AHH" throughout section for clarification.

10. (Section 1) **Utilization Review Plan** – added for clarification.

OUTPATIENT PRE-CERTIFICATION (CMC/AHH ONLY)

The following services require pre-certification:

1. Outpatient chemotherapy/radiation therapy at a facility or Physician's office.
2. Outpatient dialysis.

If You fail to notify Your pre-certification company of an Outpatient chemotherapy/radiation therapy or dialysis service within 72 hours prior to the service, the benefits otherwise payable under this Plan will be reduced by **$200**. This penalty will be applied to Covered Expenses before application of any Deductibles and coinsurance and will not contribute to out-of-pocket limits.

NOTE: These Outpatient pre-certification requirements do not apply to services within the Health Traditions Preferred Provider network.

11. (Section 1) **Medical Covered Expenses** – amended to clarify mandated preventive benefits.

PREVENTIVE CARE BENEFIT

Preventive Care services as outlined by Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services require non-grandfathered group health plans to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography and prevention issued in or around November 2009. For the most current listing, please visit the USPSTF website at http://www.uspreventiveservicestaskforce.org.
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. http://www.cdc.gov/vaccines/acip/index.html

3. With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The HRSA supports the comprehensive guidelines in the *Periodicity Schedule of the Bright Futures Recommendations* for Pediatric Preventive Health Care and the *Recommended Uniform Screening Panel* of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx

4. With respect to women, evidence-informed Preventive Care and screening provided for in comprehensive guidelines supported by HRSA to the extent not already included in the current recommendations of the USPSTF. http://www.hrsa.gov/womensguidelines

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

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

Preventive Services for Adults

1. Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked.
2. Alcohol misuse screening and counseling.
3. Blood pressure screening.
4. Bowel preps for use in colorectal cancer screening for adults ages 50 to 75.
5. Cholesterol screening for men ages 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease, for men ages 35 and older for lipid disorders and for women ages 20 and older for lipid disorders if they are at increased risk for coronary heart disease.
6. Colorectal cancer screening for adults ages 50 to 75. Screenings include but are not limited to Cologuard, colonoscopy, CT colonography, flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, gFOBT, FIT, FIT-DNA, serology tests and other tests and procedures that are medically recognized and are non-Experimental/Investigational in nature. This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.
7. Depression screening.
8. Type 2 diabetes screening for adults ages 40 to 70 who are overweight or obese.
9. Diet and physical activity counseling to prevent cardiovascular disease for adults with cardiovascular risk factors (i.e., those who are overweight or obese and have additional cardiovascular disease risk factors).
10. Hepatitis B screening for adults at high risk for infection.
11. Hepatitis C virus infection screening for adults at high risk for infection and one-time screening for adults born between 1945 and 1965.
12. HIV screening for adults ages 18 to 65 and for older adults who are at increased risk.
13. Immunization vaccines for adults – Doses, recommended ages and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster (shingles)
    d. Human Papillomavirus (HPV)
    e. Influenza (flu)
    f. Measles, Mumps, Rubella
    g. Meningococcal (e.g., meningitis)
    h. Pneumococcal (e.g., pneumonia)
    i. Tetanus, Diphtheria, Pertussis (whooping cough)
    j. Varicella (chicken pox)

14. 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.

15. Lung cancer annual screening with low-dose computed tomography in adults ages 55 to 80 who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

16. 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.

17. Prevention of falls: Physical therapy for community-dwelling adults ages 65 and older who are at risk for falls.

18. Sexually transmitted infections – Intensive behavioral counseling for adults who are at increased risk for sexually transmitted infections.

19. Skin cancer behavioral counseling for adults ages 18 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.

20. Syphilis screening for adults at increased risk.

21. Tobacco use screening and behavioral interventions and FDA-approved pharmacotherapy for cessation for all adult tobacco users.

22. Vitamin D supplements, OTC only, to prevent falls in community-dwelling adults ages 65 and older.

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

1. Bacteriuria urinary tract or other infection screening for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

2. BRCA risk assessment and counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.

3. Breast cancer chemoprevention counseling and medications for women at higher risk.

4. Breast cancer mammography screening every 1 to 2 years for women ages 40 and over.

5. 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. Breast pumps purchased from a retail store will be paid at the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply. Purchases from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement.

6. Cervical cancer and dysplasia screening for women ages 21 to 65 with cytology (Pap smear) every 3 years or, for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

7. Chlamydia and gonorrhea screening in sexually active women age 24 or younger and in older women who are at increased risk for infection.

8. Domestic/intimate partner violence – Annual screening and counseling for interpersonal and domestic violence for women of childbearing age.

9. Folic acid daily supplements containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women who may become pregnant.

10. Gestational diabetes screening in pregnant women after 24 weeks of gestation and at the first prenatal visit for pregnant women who are high risk.

11. Hepatitis B screening for pregnant women.

12. Human papillomavirus (HPV) DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.

13. Osteoporosis screening for women ages 65 and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.

14. Preeclampsia prevention low-dose aspirin for pregnant women after 12 weeks of gestation who are at high risk.

15. 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.

16. Sexually transmitted infections counseling for sexually active women.

17. Syphilis screening for all pregnant women.

18. Tobacco use screening and behavioral interventions for cessation for all pregnant women who use tobacco.

19. 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

1. Alcohol and drug use assessments.

2. Autism screening for children at 18 and 24 months.

3. Behavioral assessments.

4. Blood pressure screening.

5. Congenital hypothyroidism screening for all newborns.

6. Critical congenital heart disease screening for all newborns.

7. 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.

8. Depression screening for children ages 11 years and older.

9. Developmental screening for children under age 3 and surveillance throughout childhood.

10. Dyslipidemia screening.

11. Gonorrhea prevention medication for the eyes of all newborns.

12. Hearing screening for all newborns.

13. Height, weight and Body Mass Index measurements.

14. Hematocrit or hemoglobin screening.

15. Hemoglobinopathies or sickle cell screening for newborns.

16. Hepatitis B screening for children at high risk for infection.

17. HIV screening for children ages 15 to 17 years and for younger children who are at increased risk.

18. Immunization vaccines for children from birth to age 18 – Doses, recommended ages and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis (whooping cough)
    b. Haemophilus influenza type b (Hib disease)
    c. Hepatitis A
    d. Hepatitis B
    e. Human Papillomavirus (HPV)
    f. Inactivated Poliovirus
    g. Influenza (flu)
    h. Measles, Mumps, Rubella
    i. Meningococcal (e.g., meningitis)
    j. Pneumococcal (e.g., pneumonia)
    k. Rotavirus
    l. Varicella (chicken pox)

19. Lead screening.

20. Medical history.

21. Obesity screening for children ages 6 years and older followed by comprehensive, intensive behavioral interventions to promote improvement in weight status.

22. Oral health risk assessment.

23. Phenylketonuria (PKU) screening for this genetic disorder in newborns.

24. Sexually transmitted infections – Intensive behavioral counseling for all sexually active adolescents.

25. Skin cancer behavioral counseling for children who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.

26. Syphilis screening for children at increased risk.

27. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

28. Tuberculin testing.

29. Vision acuity screening for all children.

12. (Section 1) **Medical Covered Expenses** – removed travel immunizations from Other Covered Expenses section and added to additional preventive care section for clarification and removed virtual colonoscopy from additional preventive care section since it is now a mandated service.

PREVENTIVE CARE BENEFIT

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

1. Breast cancer mammography screening coverage is increased to include screenings without age or frequency limitations.

2. Cervical cancer and dysplasia screening is increased to include screenings without age or frequency limitations.

3. Cholesterol and dyslipidemia screening coverage is increased to include screenings without age or risk limitations.

4. Type 2 diabetes screening coverage is increased to include screenings without age or risk limitations.

5. Immunizations for the purpose of travel.

6. Prostate cancer screening.

7. Routine vision exam (excluding refraction) and hearing exam (one per contract year).

13. **Medical Covered Expenses** – removed iron supplements from covered drugs list since they are not mandated prescription drugs.

14. (Section 1) **Medical Covered Expenses** – amended for clarification.

CONVALESCENT NURSING HOME BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Convalescent Nursing Home which:

1. Begins within 14 days after discharge from an inpatient Hospital Confinement of at least three consecutive days, prior Convalescent Nursing Home Confinement of at least three consecutive days or Outpatient observation (in lieu of Inpatient admission). If the Covered Person is Medicare eligible, the Confinement must meet Medicare guidelines;

2. Is necessary for care or treatment of the same Injury or Sickness which caused the prior Confinement or Outpatient observation; and

3. Occurs while You are under the regular care of the Qualified Practitioner who certified the required Convalescent Nursing Home Confinement.

Covered Expenses will include semi-private daily room and board, including general nursing services and necessary miscellaneous services and supplies. Benefits are limited to 30 days per Contract Year for each episode of Sickness.

15. (Section 1) **Medical Covered Expenses** – amended for clarification.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT

Covered Expenses will be reimbursed for the following expenses Incurred for treatment of a Mental and Nervous Condition or for Substance Abuse:

1. Charges made by a Qualified Practitioner;

2. Charges made by a Qualified Treatment Facility;

3. Charges for Drugs which may be obtained only on the written prescription of a Qualified Practitioner.

Inpatient Benefits
Covered Expenses while confined as a registered bed patient in a Qualified Treatment Facility are payable as shown in the Schedule of Benefits. Treatment includes residential treatment services.

Outpatient Benefits
Covered Expenses for outpatient treatment received while not confined in a Hospital or Qualified Treatment Facility are payable as shown in the Schedule of Benefits. Treatment includes partial confinement.

Limitations
Covered Expenses do not include treatment of compulsive gambling or marriage counseling.

16. (Section 1, Item 11) **Medical Covered Expenses** – amended for clarification.

OTHER COVERED EXPENSES

11. Services and supplies in connection with elective sterilizations, vasectomies and tubal ligations (refer to Preventive Care benefit section for female sterilization).

17. (Section 1, Item 25) **Medical Covered Expenses** – added for clarification.

OTHER COVERED EXPENSES

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

18. (Section 1, Item 26) **Medical Covered Expenses** – added for coverage of sex reassignment services.

OTHER COVERED EXPENSES

26. The following sex reassignment services when ordered by a provider or Physician:
    a. Psychotherapy.
    b. Pre- and post-surgical hormone therapy.
    c. Sex reassignment surgery/ies. Surgery must be performed by a qualified provider.

19. **Limitations and Exclusions** – removed sex-change exclusion since it is now covered, removed Title XVIII exclusion to not conflict with Coordination of Benefits section, and renumbered remaining items.

20. (Section 1; Items 2-3, 15, 41, 54, and 63) **Limitations and Exclusions** – amended for clarification.

2. Eye refractive disorders, vision therapy (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, contact lenses (including for the treatment of keratoconus), hearing aids or the fitting or repair of any hearing aid or eyeglasses, except as specified by the Plan. The initial purchase of eyeglasses or contact lenses following cataract surgery is a Covered Expense. This exclusion does not apply to cochlear implants, which must be approved in advance by CBA.

3. 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.

15. Injury or Sickness 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 files, or if filed, that a conviction results. 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).

41. Treatment, services and supplies provided in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet, or the cutting, trimming or other non-operative partial removal of toenails. Medically Necessary pedicures provided by a qualified Health Care Professional are considered a Covered Expense.

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

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

21. (Section 2) **Definitions** – amended for clarification.

Adverse Benefit Determination:
Adverse Benefit Determination shall mean any of the following:

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

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

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

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

Confinement:
Confinement means being admitted to a Hospital, Convalescent Nursing Home or other Qualified Treatment Facility for treatment where charges are made for Room and Board to the Covered Person as a result of such treatment. Confinement does not include observational care.

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

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

Hospital:

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.

Inpatient:

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

Maximum Amount and/or Maximum Allowable Charge:

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

1. The Usual and Customary amount;

2. The allowable charge specified under the terms of the Plan;

3. The Reasonable charge specified under the terms of the Plan;

4. The actual billed charges for the covered services.

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

Preventive Care:

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

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;

2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;

3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and

4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

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

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

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

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

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

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

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

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

22. (Section 3) **Eligibility and Effective Date of Coverage** – amended for clarification.

CHANGE IN STATUS
If You have a change in status, as defined by the IRS, You have 31 days from the date of that change to make new elections under this Plan or request termination of coverage. Any changes in Your elections must be consistent with Your change in status or they will not be allowed. Change in status means a change as stated below.

This listing is not meant to be a complete listing of eligible change in status events according to the IRS regulations. If You have questions regarding whether an event qualifies as a change in status, please contact Your Plan Administrator.

2. **Number of Dependents.** An increase or decrease in the number of Dependents You have due to birth, legal guardianship, adoption, placement for adoption or the death of a dependent;

23. (Section 3) **Eligibility and Effective Date of Coverage** – amended for clarification.

GINA

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

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

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

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

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

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

24. (Section 3) **Continuation of Coverage** – amended for clarification.

EMPLOYER CONTINUATION COVERAGE

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.

25. (Section 3) **Continuation of Coverage** – amended for clarification.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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 Covered Person'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 Covered Person 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. Covered Persons may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Covered Persons 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.

26. (Section 4) **Plan Document** – amended for clarification.

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, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

27. (Section 4) **Plan Document** – amended for clarification.

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, on 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 Covered Persons and/or the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. 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 and Summary Plan Description 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 the Plan Sponsor and may be inspected at any time during normal working hours by any Covered Person.

28. (Section 4) **Coordination of Benefits** – amended for clarification.

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan including coordination being applicable to prescription drug benefits available under a prescription drug card.

29. (Section 4) **Coordination of Benefits** – amended for clarification.

Excess Insurance
If at the time of Injury, Sickness, 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.

30. (Section 4) **Coordination of Benefits** – amended for clarification.

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

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

31. (Section 4) **Coordination of Benefits** – amended for clarification.

Effect on Benefits:

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 depend child; and

   c. 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;
   d. 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.

32. (Section 4) **Coordination of Benefits** – amended for clarification.

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

33. (Section 4) **Coordination of Benefits** – amended for clarification.

Provision for Coordination of Benefits with Medicare

Definitions

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

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

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

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

Except that:

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

34. (Section 4) **Third Party Recovery, Subrogation and Reimbursement** – amended for clarification.

Subrogation
If the Covered Person(s) fails to file a claim or pursue damages against:

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.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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.

35. (Section 4) **Third Party Recovery, Subrogation and Reimbursement** – amended for clarification.

Right of Reimbursement
The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, Disability or other expenses. If the Covered Person's/Covered Persons' 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 Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person 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.

36. (Section 4) **General Provisions** – amended for clarification.

FRAUD

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person'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 Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person 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 Covered Person 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 Covered Person and their entire family unit of which the Covered Person 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 Covered Person 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.

37. (Section 4) **General Provisions** – amended for clarification.

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 Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. In such case, the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, or his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, 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.

38. (Section 4) **General Provisions** – amended for clarification.

STATEMENTS

All statements made by the company or by a Covered Person 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 Covered Person.

Any Covered Person 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 Covered Person 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.

39. (Section 4) **General Provisions** – amended for clarification.

MENTAL HEALTH PARITY

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

40. (Section 4) **General Provisions** – added for clarification.

RIGHT OF RECOVERY

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

BINDING ARBITRATION

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

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

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

The Covered Person 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 Covered Person 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 Covered Person 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 Covered Person.

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 Covered Person 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 Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

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

UNCLAIMED SELF-INSURED PLAN FUNDS

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

41. (Section 4) **Claim Procedures** – amended for clarification.

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

42. (Section 4) **Claim Procedures** – amended for clarification.

WHEN HEALTH CLAIMS MUST BE FILED

Post-service health claims, which must be Clean Claims, must be filed with the Contract Administrator within 365 days of the date charges for the service 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.**

43. (Section 4) **Claim Procedures** – amended timeframes per DOL regulations.

TIMING OF CLAIM DECISIONS

The Plan Administrator shall notify the Covered Person, 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:

1. Pre-service Urgent Care Claims:
   a. If the Covered Person 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.

   b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person 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.

   c. The Covered Person will be notified of a determination of benefits as soon as possible, but no later than 48 hours, taking into account the medical exigencies, after the earliest of:
      1) The Plan's receipt of the specified information; or
      2) The end of the period afforded the Covered Person to provide the information.

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

44. (Section 4) **Claim Procedures** – amended for clarification.

TIMING OF CLAIM DECISIONS

3. Concurrent Claims:
   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person 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 Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person 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.

   b. Request by Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person 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 Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person 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.

45. (Section 4) **Claim Procedures** – amended for correct contact information.

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

46. (Section 4) **Claim Procedures** – amended for clarification.

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

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

47. (Section 4) **Claim Procedures** – amended for clarification.

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding the 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.**

48. (Section 4) **Claim Procedures** – amended for clarification.

External Review Process

1. Scope
The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

a. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

b. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

49. (Section 4) **Claim Procedures** – amended for clarification.

External Review Process

2. 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).

b. 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:
   2) 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);
   3) 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

50. (Section 4) **Claim Procedures** – amended for clarification.

External Review Process

3. Expedited external review
a. 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:
   1) 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

2) 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, available of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from the facility.

b. 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.

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

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

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

51. (Section 4) **Claim Procedures** – amended for clarification.

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

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

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

52. (Section 4) **Claim Procedures** – amended to remove reference to specific ICD version.

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

53. (Section 4) **Claim Procedures** – amended for clarification.

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

6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

54. (Section 4) **Claim Procedures** – added for clarification.

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

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

55. (Section 4) **HIPAA PRIVACY** – amended for clarification.

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Privacy Officer as outlined in the Health Insurance Portability and Accountability (HIPAA) section.

Definitions

Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

56. (Section 4) **HIPAA PRIVACY** – amended for clarification.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

13. Train Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals identified above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

57. (Section 4) **HIPAA PRIVACY** – amended for clarification.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. 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.

58. (Section 4) **HIPAA PRIVACY** – amended for clarification.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI
4. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

59. (Section 4) **HIPAA PRIVACY** – amended for clarification.

Covered Person's Rights
The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

2. Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests;

3. The Covered Person 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 Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer;

5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy his/her PHI, or to have a copy of his/her PHI transmitted directly to another designated person, he/she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial;

6. Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

7. Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

60. (Section 4) **HIPAA PRIVACY** – amended for clarification.

Contact Information

Privacy Officer Contact Information:

61. (Section 4) **HIPAA SECURITY** – amended for clarification.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach notification must be provided to individual by:
   a. Written notice by first-class mail to the Covered Person (or next of kin) at the last known address or, if specified by the Covered Person, e-mail;
   b. If the Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form;
   c. If an urgent notice is required, the Plan may contact the Covered Person by telephone.
      i. The breach notification will have the following content:
         a) Brief description of what happened, including date of breach and date discovered;
         b) Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
         c) Steps the Covered Person should take to protect from potential harm;
         d) What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;