FOREST LAKE AREA SCHOOLS #831
LIMITED SCOPE HEALTH REIMBURSEMENT ARRANGEMENT

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ARTICLE I.
INTRODUCTION

1.1 **Establishment.** The Employer hereby adopts, effective November 1, 2013, the Forest Lake Area Schools Limited Scope Health Reimbursement Arrangement (the "Plan").

1.2 **Purpose.** The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for certain Health Care Expenses as provided in this Plan. It is the intention of the Employer that the benefits provided and payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Sections 105(b) and 106 of the Code. In addition, it is the intention of the Employer that the Plan qualify as a Health Reimbursement Arrangement ("HRA") under IRS Revenue Ruling 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

1.3 **HIPAA Privacy and Security Rules.** This Plan is a "covered entity" for purposes of the Privacy Rules and Security Rules as described in greater detail in Article VIII below.

1.4 **Health Care Reform.** The Plan is intended to be exempt from the provisions of the Patient Protection and Affordable Health Care Act ("PPACA"), as amended, because it is an excepted benefit under HIPAA.

1.5 **Not ERISA Plan**. This Plan is not an employee welfare benefit plan for purposes of ERISA. Plan sponsored by public sector entities are not subject to ERISA.

ARTICLE II.
DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 **Authorized Representative** means, for the claims and appeal procedures, the person entitled to act on behalf of the claimant with respect to a benefit claim or appeal. In order for the Plan to recognize a person as an Authorized Representative, written notification to that affect signed by the claimant and notarized must be received by the Plan. An assignment for purposes of payment is ***not*** designation of an "Authorized Representative."

2.2 **Claims Administrator** means the entity that has been appointed under Section 9.1(c) to be responsible for administering claims for benefits under the Plan.

2.3 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.4 **Covered Individual** means a Participant, Dependent of a Participant and the Spouse of a Participant, and any other person appropriately covered under the Plan.

2.5 **Dependent** means an individual (other than the Participant and the Participant's Spouse) with respect to whom group health plan benefits are excluded from the Participant's income under Section 105(b) of the Code.

2.6 **Employee** means any person employed by the Employer and on the Employer's W-2 payroll on or after the Effective Date, except that it shall not include:

(a) any employee included within a unit of employees covered by a collective bargaining unit unless such agreement provides, whether specifically or generally, for coverage of the employee under this Plan;

(b) any employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States;

(c) any employee who is a leased employee as defined in Section 414(n)(2) of the Code;

(d) an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; or

(e) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

2.7 **Employer Contribution** means a nonelective contribution made by the Employer on behalf of each Participant in the Plan. The Employer Contribution is an amount that has not been actually or constructively received by the Participant, and it is made available to the Participant exclusively for reimbursement of eligible expenses under the Plan.

2.8 **Entry Date** means the date as of which an Employee would become covered under the group medical plan sponsored by the Employer if the Employee has enrolled in that coverage.

2.9 **ePHI** means PHI maintained or transmitted in electronic media, including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.10 **ERISA** means the Employee Retirement Income Security Act of 1974 and regulations thereunder, as amended from time to time.

2.11 **HC Account** means "health care account" and is the record keeping account established under the Plan for each Participant.

2.12 **Health Care Expense** means an expense for dental or vision care that qualifies as medical care under Section 213(d) of the Code and that meets the definition of dental benefits or vision benefits (as applicable) under Treas. Reg. § 54.9831-1(c)(3)(iii). Notwithstanding the foregoing, if the Employer sponsors a cafeteria plan, Health Care Expense shall not include premiums that may be paid on a pre-tax basis in accordance with the terms of such cafeteria plan. Health Care Expense includes expenses for over-the-counter drugs and medicines for dental or vision care only if such drug or medicine has been prescribed in accordance with Section 106(f) of the Code.

2.13 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder, as amended from time to time.

2.14 **Health Reimbursement Arrangement ("HRA")** means an employer funded medical reimbursement program within the meaning of IRS Revenue Ruling 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

2.15 **Highly Compensated Individual** means an individual who is (1) one of the five (5) highest paid officers or (2) among the highest paid 25 percent of all Employees other than excludable Employees identified in Section 105(h) of the Code.

2.16 **Managing Body** means the person or persons with authority to make decisions for the Employer.

2.17 **Participant** means an Employee who has become and not ceased to be a Participant pursuant to Article III. In addition, Participant includes persons "deemed" to be Participants under a specific provision of this Plan.

2.18 **PHI** means health information that:

(a) Is created or received by a health care provider, health plan, or health care clearinghouse;

(b) Relates to the past, present, or future physical or mental health or condition of an individual (including "genetic information" as that term is defined in the Genetic Information Nondiscrimination Act of 2008); 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

(c) Either identifies the individual or reasonably could be used to identify the individual.

2.19 **Plan** means the Forest Lake Area Schools #831 Limited Scope Health Reimbursement Arrangement, as may be amended from time to time.

2.20 **Plan Administrator** means the entity, person or persons determined under Section 9.1.

2.21 **Plan Year** means the twelve (12) month period beginning on July 1 and ending on June 30. The initial Plan Year may be a "short" Plan Year beginning on November 1, 2013 and ending on June 30, 2014. The records of the Plan will be kept based upon the Plan Year.

2.22 **Privacy Rules** means the *Standards of Privacy of Individually Identifiable Health Information* at 45 C.F.R. part 160 and part 164 at subparts A and E.

2.23 **Security Incident** means "security incident" as defined in 45 C.F.R. Section 164.304, which generally defines "security incident" to include attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI.

2.24 **Security Rules** means the Security Standards and Implementation Specifications at 45 C.F.R. Part 160 and Part 164, subpart C.

2.25 **Spouse** means an individual who is legally married to a Participant and who is treated as a "spouse" under the Code.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility Requirements.** Each Employee who meets the following conditions shall be eligible to participate in this Plan:

(a) Is a member of the FLAPOP bargaining unit (for clerical Employees);

(b) Is eligible for coverage under the group medical plan sponsored by the Employer; and

(c) Has waived coverage under the group medical plan sponsored by the Employer.

3.2 **Participant Status.** An Employee who has met the eligibility requirements described in Section 3.1 shall become a Participant as of the Entry Date.

3.3 **Conditions of Participation.** As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Claims Administrator and Plan Administrator with respect to any provider of services involved in a claim under this Plan;

(c) Submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Claims Administrator and Plan Administrator may reasonably require; and

(d) Cooperate with all reasonable requests of the Claims Administrator and Plan Administrator that may be necessary for the proper administration of the Plan.

Failure to comply with such conditions relieves the Plan, Plan Administrator, Claims Administrator, and Employer of any obligations under this Plan with respect to that Participant and any others claiming entitlement to benefits under this Plan through that Participant and shall result in the termination of the Participant's participation in the Plan.

3.4 **Termination of Participation.** A Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:

(a) The date of the death of the Participant;

(b) The date of termination of the Participant's employment with the Employer;

(c) The date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time in accordance with Article IV;

(d) The balance of the Participant's HC Account is zero and no further contributions will be made to the HC Account; or

(e) The date of termination of the Plan in accordance with Article IV.

Participation may also terminate for cause, including for failing to comply with the conditions of participation described in Section 3.3 and/or for making fraudulent or improper claims. In certain cases, if participation is terminated for cause, the Participant's coverage may be terminated

retroactively to the date on which the event giving rise to the cause occurred. Termination of participation in this Plan shall not prevent a former Participant from receiving continuation coverage required by applicable law.

ARTICLE IV.
BENEFITS UNDER THE PLAN

4.1 **Benefits.** The Plan shall reimburse Health Care Expenses in accordance with this Article IV.

4.2 **Health Care ("HC") Account.** The HC Account will be credited with the Employer Contribution. A Participant's HC Account will be decreased from time to time in the amount of payments made to the Participant for Health Care Expenses. The balance of the HC Account as of the close of the Plan Year will be carried over to the next Plan Year.

4.3 **Claims for Reimbursement.** A Participant may make a claim by completing a claim form and submitting such form to the Claims Administrator (or its designee) via email, facsimile, mail, or the Claims Administrator's website setting forth at least the following:

(1) the amount, date and nature of the expense, including the identity of the individual who incurred the expense;

(2) the name of the person or entity to which the expense was paid;

(3) the Participant's statement that the expense has not been reimbursed and the Participant will not seek reimbursement for the expense; and

(4) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by such bills, invoices, receipts, explanations of benefits ("EOB") issued by a health plan, or other statements from an independent third party as is necessary to establish that an eligible expense has been incurred and the amount of the expense. If the claim is for an over-the-counter drug or medicine, the claim form must be accompanied by the prescription. The Claims Administrator is entitled to rely on the information provided on the claim form in processing claims under this Plan. A claim for a Health Care Expense incurred during the Plan Year must be submitted for payment within ninety (90) days following the end of the Plan Year. Where circumstances beyond the Participant's control prevent submission within the described time frame, notice of a claim with an explanation of the circumstances may be accepted by the Claims Administrator as a timely filing. Claims shall be determined in accordance with Article VI.

4.4 **Incurred Expenses.** To be reimbursable, the Participant must have incurred a Health Care Expense after his/her Entry Date. An expense is "incurred" when the Participant is provided with the care giving rise to the eligible expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.

4.5 **Timing of Reimbursement.** Participants shall be reimbursed weekly.

4.6 **Maximum Reimbursement.** The maximum reimbursement a Participant may receive at any time shall be the amount of the Participant's HC Account balance at the time the reimbursement request is processed. The maximum reimbursement requirements apply to the Participant, Spouse, and Dependents on an aggregate basis, not an individual basis. If a Participant's claim is for an amount that is more than the Participant's current HC Account balance, the excess, unreimbursed part of the claim will be carried into the subsequent month(s), to be paid as the balance of the Participant's HC Account becomes adequate. Notwithstanding the foregoing, the excess, unreimbursed portion of a claim will not be carried over into the subsequent month(s) if no further contributions will be made to the Participant's HC Account under Article V.

4.7 **Termination of Participation.**

(a) **Cases other than Death.** Notwithstanding anything herein to the contrary, if the Participant's participation would otherwise terminate under Section 3.4(b) or (c), the former Participant may continue to access the HC Account following termination of participation for purposes of obtaining reimbursement of Health Care Expenses. Such access shall continue until the earliest to occur of the events identified in Section 4.5(a), (d), or (e). Such access shall also be provided to those individuals, if any, who at the time of the termination of the Participant's participation were the Participant's Spouse or Dependents. Such access to the Participant's HC Account by a Spouse and Dependents shall cease upon the earlier of the date of termination of the Participant's access or the date the Spouse ceases to be a Spouse or the Dependent ceases to be a Dependent, as the case may be. If continuation coverage is required by applicable law, the access described in this Section 4.7(a) shall be provided only if offered as and selected in lieu of such continuation coverage.

(b) **Death.**

i. Notwithstanding anything herein to the contrary, in the event a Participant's participation in the Plan terminates because of the Participant's death, the Participant has no surviving Spouse or Dependents, and the former Participant incurred a Health Care Expense prior to the Participant's death that would have been reimbursable out of the Participant's HC Account but that has not been submitted for reimbursement, the deceased Participant's estate may submit such Health Care Expense for reimbursement in accordance with Section 4.3. A certified copy of the deceased Participant's death certificate and proof that the person acting upon behalf of such Participant's estate has authority to do so must be submitted with such claims.

ii. Notwithstanding anything herein to the contrary, the deceased Participant's surviving Spouse and Dependents, if any, may continue to access the Participant's HC Account for purposes of obtaining reimbursement of Health Care Expenses until the earlier of: (1) the date on which the HC Account balance reaches zero; or (2) the date on which the surviving Spouse and Dependents die. No claim shall be paid to a surviving Spouse or Dependent pursuant to this subsection (ii) unless a certified copy of the deceased Participant's death certificate has been provided to the Claims Administrator. If continuation coverage is required by applicable law, the access described in this Section 4.7(b)(ii) shall be provided only if offered as and selected in lieu of such continuation coverage.

iii. No one other than the Participant's Spouse and Dependents may have access to the Participant's HC Account following the Participant's death.

4.8 **Nondiscrimination.** This Plan is intended to be nondiscriminatory and to meet the requirements under applicable section of the Code. If the Plan Administrator determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements.

4.9 **HC Account Forfeitures.** Any amount remaining in a Participant's HC Account shall be forfeited following the later to occur of: (1) the termination of Participant's participation in the Plan, (2) the termination of any continuation coverage provided by the Plan under applicable law, or (3) the termination of any coverage provided by the Plan in lieu of continuation coverage required by applicable law. Forfeited amounts shall revert to the Employer.

4.10 **Medical Support Orders.** Notwithstanding any provision of this Plan to the contrary this Plan shall recognize medical child support orders as required under state law or under the Child Support Performance and Incentive Act of 1998. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.

4.11 **Coordination with Cafeteria Plan.** To the extent the Employer also sponsors a medical reimbursement program as part of its cafeteria plan within the meaning of Section 125 of the Code, a Participant participates in the medical reimbursement program, and the Participant or a Covered Individual covered through such a Participant incurs an eligible Health Care Expense that is also eligible for reimbursement under the medical reimbursement program, the medical reimbursement program shall pay prior to this Plan.

4.12 **Further Limitations on Benefits**.

(a) This Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or by the Participant, the Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

ARTICLE V.
CONTRIBUTIONS

5.1 **Employer Contributions**. The Employer shall make a fixed contribution per Participant. The amount and timing of the Employer Contribution shall be determined by the terms and conditions of the applicable collective bargaining agreement, personnel policy, or employee contract. The amount of the Employer Contribution may change from time to time. Any such change will be communicated to the Participants.

5.2 **No Employee Contributions**. Except for contributions required for continuation coverage as described in Article XI, no contributions other than Employer Contributions are required nor will they be accepted.

5.3 **No Trust**. All contributions shall allocated to the HC Accounts, but shall be held in the Employer's general assets. There is no separate trust.

ARTICLE VI.
CLAIMS DETERMINATIONS AND REVIEW OF DENIED CLAIM

6.1 **General Provisions.** All claims and appeals will be adjudicated in a manner so that the independence and impartiality of the persons involved in making the determination are ensured. Decisions regarding hiring, compensation, termination, and similar matters with respect to any individual involved in the determination (e.g., a claims adjudicator or medical expert) shall not be based upon the likelihood that the individual will support a denial of benefits.

6.2 **Initial Claim Determination.**

(a) **Time Frame for Decision**. The Plan must determine the claim within thirty (30) days of receipt of the claim.

(b) **Extension of Time**. If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan must notify the claimant or the claimant's Authorized Representative prior to the expiration of the initial thirty (30) day time period for determining the claim. This extension is only available once.

Notification: The notification of the need for the extension must include a description of the "matters beyond the Plan's control" that justify the extension and the date by which a decision is expected.

(c) **Incomplete Claims**. There is no special rule if a claim is incomplete. Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the claimant is appropriately notified, the Plan's period of time to make a decision is "tolled."

Tolling: The period of time in which the Plan must determine a claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the claimant responds.

Notification: For this purpose, notification can be made orally to the claimant or the health care professional, unless the claimant requests written notice.

The notification will include a time frame in which the necessary information must be provided. Once the necessary information has been provided, the Plan must decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be decided without that information.

6.3 **Decision.**

(a) **Notification of Decision**. Written (or electronic) notification of the Plan's determination must be provided to the claimant or the claimant's Authorized Representative. Such notification must be provided only where the decision is adverse.

"**Adverse**" means:
- A denial, reduction, or termination of a benefit;
- A failure to provide or make payment (in whole or in part) for a benefit; or

(b) **Adverse Decision**. For adverse claim determinations, the notification shall at a minimum:

- State the specific reason(s) for the determination;
- Reference specific Plan provision(s) upon which the determination is based;
- Describe additional material or information necessary to complete the claim and why such information is necessary;
- Describe Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures;
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request); and
- Where the decision involves scientific or clinical judgment, disclose either (1) an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances, or (2) a statement that such explanation will be provided at no charge upon request; and

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(c) **Not Adverse Decision**. For claim determinations that are not adverse, notice will be provided that informs the claimant or the claimant's Authorized Representative the claim has been accepted.

6.4 Access to Relevant Documents.

In order (1) to evaluate whether to request review of an adverse determination, and (2) if review is requested, to prepare for such review, the claimant or the claimant's Authorized Representative will have access to all relevant documents.

Relevant: A document, record or other information is "relevant" if it was relied upon in making the determination, or was submitted to the Plan, considered by the Plan, or generated in the course of making the benefit determination without regard to whether it was relied upon.

6.5 Appealing a Denied Claim.

If a claim is denied, in whole or part, the claimant or the claimant's Authorized Representative may request the denied claim be reviewed.

(a) **Requesting Review**. The claimant or the claimant's Authorized Representative has a period of 180 days to appeal the claim determination. The appeal request must be in writing and should be sent to the address specified in the notification of adverse decision described above.

(b) **Submission & Consideration of Comments**. The claimant or the claimant's Authorized Representative will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the adverse benefit determinations will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(c) **Consultation with Independent Medical Expert**. In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted, if any, during the initial determination or a subordinate of that individual.

Disclosure: If the advice of a medical or vocational expert was obtained by the Plan in connection with the claim denial, the names of each such expert shall be provided, regardless of whether the advice was relied upon.

(d) **Time Frame for Decision**. If claimant or the claimant's Authorized Representative requests a review of a denied claim within the time frame described above, the Plan Administrator shall review the claim and make a determination no later than 60 days from the date the review request was received.

(e) **Decision**. The review of the claim will be conducted by the Plan Administrator. It will be made by a person different from the person who made the initial determination and such person will not be a subordinate of the original decision maker. The information in the administrative record shall be reviewed. Additional information submitted shall be considered. The decision shall be based upon that information plus the terms of the Plan and past interpretations of the same and similar Plan provisions. The Plan Administrator may rely upon protocols, guidelines, or other criterion.

(f) **Notification of Decision**. Written (or electronic) notification of the Plan Administrator's determination must be provided to the claimant or the claimant's Authorized Representative. Such notification must be provided whether the decision is adverse or not adverse.

"**Adverse**" means:
- A denial, reduction, or termination of a benefit;
- A failure to provide or make payment (in whole or in part) for a benefit, or

(g) **Adverse Decision**. For adverse appeal determinations, the notification shall reflect at least the following:

- State the specific reason(s) for determination;
- Reference specific Plan provision(s) upon which the determination is based;
- Disclose any internal rules, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information

relevant to the determination; and

- Where the decision involves scientific or clinical judgment, disclose either (1) an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances, or (2) a statement that such explanation will be provided at no charge upon request; and

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(h) **Not Adverse Decision**. For claim determinations that are not adverse, notice will be provided that informs the claimant or the claimant's Authorized Representative the decision has been reversed, and the claim accepted.

ARTICLE VII.
HIPAA PRIVACY AND SECURITY PROVISIONS

The Privacy Rules and Security Rules under HIPAA apply to the Plan.

7.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent allowed by, and in accordance with the uses and disclosures permitted by, HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Employer in accordance with this Article VII, the Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) coordination of benefits;

(3) adjudication of health benefits claims (including appeals and other payment disputes);

(4) subrogation of health benefit claims;

(5) establishing employee contributions;

(6) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) billing, collection activities, and related health care data processing;

(8) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health plan); and

(13) reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) quality assessment;

(2) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) business management and general administration activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) customer service, including data analyses for policyholders.

(8) resolution of internal grievances; and

(9) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

7.2 **Employer's Obligations under the Privacy Rules**. Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification

from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

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

7.3 **Employer's Obligations under Security Rules**. If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) report to the Plan any Security Incident of which it becomes aware; and

(d) implement reasonable and appropriate security measures to ensure that only those persons identified below have access to ePHI and that such access is limited to the purposes identified below.

7.4 **Adequate separation between the Plan and the Employer must be maintained**. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) the person employed in the position that is given primary responsibility for performing the Employer's duties as the Plan Administrator of the Plan; and

(b) staff designated by the person described in (a) above.

7.5 **Limitation of PHI Access and Disclosure**. The person(s) described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.

7.6 **Noncompliance Issues**. If the person(s) described above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.

ARTICLE VIII.
PLAN ADMINISTRATION

8.1 **Plan Administrator**.

(a) The Plan Administrator shall be responsible for the general supervision of the Plan and shall have authority to control and manage the operation and administration of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

(b) The Employer shall be the Plan Administrator unless its Managing Body designates a person or persons other than the Employer to be the Plan Administrator. The Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator.

(c) The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, and/or responsibilities regarding the operation and administration of this Plan.

8.2 **Agent for Service of Legal Process.** The agent for service of legal process for the Plan is the Plan Administrator.

8.3 **Allocation of Responsibility for Administration.** The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator, nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

8.4 **Rules and Decisions.** Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or legal counsel, or other entity acting on behalf of the Employer or Plan Administrator.

8.5 **Records and Reports.** The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

8.6 **Authorization of Benefit Payments.** The Plan Administrator (or the Claims Administrator as its designee) shall determine all benefits which are to be paid, pursuant to the provisions of the Plan.

8.7 **Other Powers and Duties of the Administrator**. The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) Discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility and to determine all questions arising in the administration and application of the Plan;

(b) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) To appoint individuals to assist in the administration of the Plan and any other agents the Plan Administrator deems advisable including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.

8.8 **Plan Interpretation.** This Plan will be administered in accordance with its terms. The Plan Administrator and the Claims Administrator (and/or other person acting as a fiduciary with respect to this Plan), to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including, but not limited to, the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Covered Individuals, claimants, and all interested parties.

ARTICLE IX.
PLAN AMENDMENT AND TERMINATION

9.1 **Amendment by Employer.** The Employer reserves the right to amend, alter, or wholly revise this Plan, prospectively or retrospectively, at any time by the action of its Managing Body, and the interest of each Participant is subject to the powers so reserved. The Employer expressly may amend, alter or wholly revise this Plan if it determines it necessary or desirable, with or without retroactive effect, to comply with the law. Such changes shall not affect any right to benefits that accrued prior to such amendments. Such amendment shall be made in writing and shall be delivered promptly to the Claims Administrator and Plan Administrator.

9.2 **Employer's Right to Terminate.** Although the Employer expects the Plan to be maintained for an indefinite time, the Employer reserves the right to terminate the Plan or any portion of the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the resolution of such successor's Managing Body. Such termination shall not affect any right to benefits that accrued prior to such termination. Such action shall be made in writing and shall be delivered to the Claims Administrator and Plan Administrator.

ARTICLE X.
GENERAL PROVISIONS

10.1 **Non-Alienation of Benefits**. Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer, Plan Administrator and/or Claims Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

10.2 **Action by Employer**. Whenever the Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the Managing Body of the Employer or such representatives of the Employer as the Managing Body may designate.

10.3 **No Guarantee of Tax Consequences**. Notwithstanding any provision in this Plan to the contrary, this Plan makes no commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not so excludable.

10.4 **Compensation and Expenses**. The Claims Administrator shall be entitled to reasonable fees for its services hereunder, which shall be described in an Administrative Services Agreement between the Claims Administrator and the Plan Administrator. Such fees and any expenses incurred by the Claims Administrator in connection with the Plan (including expenses and fees of persons hired or employed by them) shall be paid by the Employer.

10.5 **Governing Law**. This Plan shall be construed and enforced according to the laws of the State of Minnesota, except to the extent preempted by federal law.

10.6 **Family and Medical Leave Act of 1993 ("FMLA")**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with FMLA, to the extent the Employer is subject to such law.

10.7 **Newborns' and Mothers' Health Protection Act ("NMHPA").** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA. Federal law requires the following statement be included in the Plan document, verbatim:

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may

not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on pre-certification, contact your Plan Administrator.

10.8 **Women's Health and Cancer Rights Act of 1998 ("WHCRA").** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with WHCRA.

10.9 **Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with USERRA. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA and such policies shall be incorporated herein by reference.

10.10 **Plan Not a Contract of Employment**. The Plan is not an employment agreement and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

10.11 **Erroneous Payments.** If the Plan makes a payment for benefits in excess of the benefits required by the Plan or makes a payment to or on behalf of an individual who is not currently covered by the Plan, the Plan shall be entitled to recover such erroneous payment from the recipient thereof.

10.12 **Medicare Secondary Payer.** The Plan shall comply with the Medicare secondary payer rules found in 42 U.S.C. § 1395y. In general, the Plan shall pay benefits primary to Medicare if any one of the following conditions is satisfied: (a) the Employer employed twenty (20) or more employees for each working day in at least twenty (20) weeks in either the calendar year in which the claim is made or the preceding calendar year, the Participant is employed by the Employer, and the Participant is actually covered by Medicare by reason of obtaining the age of 65; (b) the Employer employed 100 or more employees on at least 50% of its regular business days during the calendar year preceding the year in which the claim was made, the Participant is employed by the Employer, and the Participant is actually covered by Medicare by reason of disability; and (c) the Participant is entitled to Medicare by reason of end stage renal disease and the claim is made during the twelve (12) month period beginning in the first month in which such Participant is entitled to benefits under Medicare (regardless of whether he/she applies for such benefits). In all other cases, the Plan shall pay benefits secondary to Medicare.

10.13 **Medicare Part D.** The Plan shall cooperate with Medicare Part D prescription drug plans (and Covered Individuals who are enrolled in such plans) with respect to coordination of benefits between the Plan and the Medicare Part D plan, including the provision of information to the Medicare Part D plan (or the Covered Individuals) regarding the benefits provided under the Plan for costs covered by the Medicare Part D plan. Covered Individuals enrolled in Medicare Part D plans shall cooperate with the Plan so that the Plan may perform its obligations under this subsection.

10.14 **Certificates of Creditable Coverage.** When coverage terminates, or upon request by a Covered Individual during coverage or within two (2) years of termination of coverage under this Plan, Covered Individuals will be provided with a certification of creditable coverage by the Plan Administrator (or its designee). A request for a certification of creditable coverage should be

directed to the Plan Administrator. Upon request, the Plan Administrator (or its designee) will issue the certification of creditable coverage as soon as reasonably possible.

10.15 **Exhaustion of Administrative Remedies; Statute of Limitations.** For all claims subject to the administrative procedures described in Article VI, exhaustion of those administrative procedures is required prior to the initiation of a legal action. Thereafter, legal action by a Participant, or someone on behalf of a Participant, must be initiated within one (1) year of receipt of the written notification of denial upon appeal. To the extent exhaustion of the appeal process is not required, a Participant, or someone on behalf of the Participant, must initiate legal action within one (1) year of having submitted the initial claim request to the Plan Administrator, or its designee. No legal action may be brought by a Participant, or someone on behalf of the Participant, after expiration of the applicable limitations period.

10.16 **Michelle's Law.** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner as required by Michelle's Law.

ARTICLE XI.
COBRA CONTINUATION

11.1 **Compliance with COBRA.** Continued coverage for the Plan shall be provided only if and as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended.

11.2 **COBRA Policies and Procedures.** To the extent not provided herein, the Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage and such policies shall be incorporated herein by reference.

11.3 **Notification Procedures.** The Plan requires the notifications described below with respect to continuation coverage under COBRA:

(a) **Notice of qualifying event.** Under the law, a Covered Individual (or a representative acting on behalf of the Covered Individual) has the responsibility to inform the Plan of a divorce, legal separation, or a child losing dependent status under the Plan (the "qualifying event") within sixty (60) days of the latest of: (i) the date of the qualifying event; (ii) the date coverage would be lost because of the qualifying event; or (iii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Plan. Oral notification, including notification by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the qualifying event;
(4) include a detailed description of the event;
(5) identify the effective date of the event; and
(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

(b) **Notice of second qualifying event.** A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to

the Plan. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event that entitled the Covered Individuals to COBRA coverage;
(5) include a detailed description of the event;
(6) identify the effective date of the event; and
(7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

(c) **Notice of disability.** A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan when a Covered Individual has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (i) the date of the disability determination; (ii) the date of the qualifying event; (iii) the date coverage would be lost because of the qualifying event; or (iv) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. Notwithstanding the foregoing, notification must be provided before the end of the first eighteen (18) months of continuation coverage. The notification must be provided in writing and be mailed to the Plan. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage;
(5) state the name of the disabled Covered Individual;
(6) identify the date upon which the disabled Covered Individual became disabled;
(7) identify the date upon which the Social Security Administration made its determination of disability; and
(8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan of that determination within thirty (30) days of the later of: (i) the date of such determination; or (ii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be in writing and be mailed to the Plan. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If the notification is not provided within the required time, the Plan reserve the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

(d) **Notice of Coverage Under Another Group Health Plan or Medicare.** A Covered Individual must notify the Plan immediately if any Covered Individuals receiving continuation coverage actually become covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a Covered Individual on continuation coverage receives any benefits under the Plan after coverage is to cease under the foregoing rule, the Plan reserves the right to seek reimbursement from such Covered Individual.

Dated: _____

FOREST LAKE AREA SCHOOLS #831

By: _____
Its: _____