Watertown School District #14-4

Summary Plan Description

Client #DD10393

January 1, 2011

DAKOTACARE Administrative Services, Inc. is the third party administrator for (Company Name)'s Self-funded Health Plan. Neither this booklet, nor any other DAKOTACARE Administrative Services, Inc. materials, shall imply that you or your dependents are insured by a DAKOTACARE Health Plan.

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SECTION I
INTRODUCTION

This document is a description of Watertown School District #14-4 Employee Benefit Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, Utilization Review or other medical management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void this coverage (and deny claims). In cases of Rescission, the Covered Person shall be notified not less than thirty (30) days before the coverage is rescinded. An independent third party review related to the Rescission decision shall be made available to the Covered Person. These provisions are explained in summary fashion in this document; additional information is available from the Claim Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination Provisions. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Coverage Selection. Explains annual selection options.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Medical Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Describes services and supplies that are **not** covered.

Prescription Drug Benefits. Defines Prescription Drug benefits.

When Claims Should Be Filed. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Responsibilities for Plan Administration. Explains the Plan's structure and the Participants' rights under the Plan.

General Plan Information.

SECTION II
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claim Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

PARTICIPANT ELIGIBILITY

A Participant eligible for coverage under the Plan shall include Employees who are in one of the following classifications:

(1) An Employee who is employed by the District as an administrator or as a salaried Certified Teacher.

(2) Classified Employees who are scheduled to work a minimum of seven (7) hours per day for one hundred seventy-eight (178) days or scheduled to work a minimum of one thousand two hundred forty-six (1246) hours annually.

(3) An Employee who retired from the District in accordance with the retirement language as identified in the District's Master Contract or has received previous approval and written notification from the District to be eligible for continuation of health plan coverage as a retiree.

With respect to such an eligible person whose initial employment with Watertown School District #14-4 commences with the school year after the effective date of the Plan, the date of eligibility shall be on the first day of the month of September or on the first day of the month of October. This date is decided upon by the eligible person.

A Participant eligible for Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent as stated later in the Plan. Each Participant will become eligible for Dependent Coverage on the latest of the following:

(1) The date the Participant becomes eligible for Participant coverage; or

(2) The date on which the Participant first acquires a Dependent.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse and children from birth to the limiting age of twenty-six (26) years When the child reaches the limiting age, coverage will end on the last day of the child's birthday month

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Claim Administrator may require documentation proving a legal marital relationship.

The term "children" shall mean an Employees own blood descendents of the first degree, lawfully adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and

unmarried. The Claim Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two (2)-year period, the Claim Administrator may require subsequent proof not more than once each year. The Claim Administrator reserves the right to have such Dependent examined by a Physician of the Claim Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Watertown School District #14-4 shall, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by Watertown School District #14-4 and the amount to be contributed (if any) by each Participant.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within twenty-four (24) months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage if he or she requests one either before losing coverage or within twenty-four (24) months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months, after the person's Enrollment Date or after the completion of ninety (90) consecutive treatment free days for that condition, ending after the coverage is effective. This time may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within ninety (90) days prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

The Pre-Existing Condition does not apply to Pregnancy or to any Covered Person that has not yet reached age nineteen (19).

Are there any exceptions for pre-existing conditions?

Any Covered Person that has not yet reached the age of nineteen (19) is not subject to the pre-existing condition limitation described herein.

With respect to a Qualified Beneficiary who elects COBRA Continuation Coverage pursuant to the American Recovery and Reinvestment Act of 2009, the following periods shall be disregarded for purposes of determining the sixty-three (63)-day break in coverage period, as referred to in Section 701(c)(2) of ERISA:

(1) The period beginning on the date of the Qualifying Event; and

(2) The period ending with the start of COBRA Continuation Coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application within thirty (30) days of becoming eligible for coverage. For Dependent coverage to be effective, the covered Employee is required to enroll for Dependent coverage.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered hospital nursery care and related routine newborn physician care will be applied toward the Plan of the covered Dependent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Claim Administrator no later than thirty (30) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

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

If application is made outside of the thirty (30) day limit, the Participant, Spouse and/or Dependents will not be considered for coverage.

COVERAGE SELECTION

Eligible Employees are required to select the benefit coverage they desire at the time of enrollment into the Plan, option A or option B. Employees desiring a change in the selected coverage may do so annually on the anniversary date of the Plan, October 1, by providing the Business Office with such a request no later than September 15. Deductible modifications will go into effect on January 1, following the request/approved change. Additionally, Employees desiring a change in the selected coverage option will be allowed to do so upon experiencing a Family status change as outlined under Special Enrollment Periods. Participating Employees wishing to make modifications in their current level of coverage must take into consideration their participation or non-participation in the District's Flex 125 Plan. The Flex 125 Plan allows for the pre-tax consideration of the Employee's premium contributions.

SPECIAL ENROLLMENT PERIODS

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

(1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and

either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a Participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee as well as other eligible Dependents) may be enrolled under this Plan.

The Dependent Special Enrollment Period is a period of thirty (30) days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, as of the date of marriage,

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) **Additional Special Enrollment Rights.** An Employee or Dependent who is eligible but not enrolled is entitled to enroll under the following circumstances:

(a) The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within sixty (60) days after termination; or

(b) The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

SPECIAL ENROLLMENT FOR PREVIOUSLY ENROLLED COVERED PERSONS

Dependents who had ceased to be eligible to enroll in the Plan prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a one-time 30 day special enrollment opportunity. This special enrollment opportunity will begin October 1, 2010**.** All dependents whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before age 26, are eligible to enroll, or re-enroll in the Plan under this special enrollment period. Coverage for dependents who enroll through this special enrollment opportunity must take effect no later than October 1, 2010**.**

Covered Persons who were previously enrolled, but were terminated from Plan participation because of a prior lifetime limitation provision shall be provided with a one-time 30 day special enrollment opportunity. This special enrollment opportunity will begin October 1, 2010. Coverage for participants who enroll through this special enrollment opportunity must take effect no later than October 1, 2010**.**

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

With respect to such an eligible person who becomes employed by Watertown School District #14-4 after the commencement of the school year after the effective date of the Plan, the date of eligibility shall be on the first day he/she becomes actively employed by the District or on the first day of the month following such employment with the District. This date is decided upon by the eligible person.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Claim Administrator for further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This

includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: A Covered Employee who ceases Active Work because of disability will nevertheless be considered as employed until the Employer, acting in accordance with rules precluding individual selection, discontinues such Employee's coverage;

For leave of absence: A Covered Employee who ceases Active Work because of an approved leave of absence, other than leave taken under FMLA, will nevertheless be considered as employed for a period of thirty-one (31) days following such cessation of Active Work and the coverage may be continued during such leave, not to exceed one (1) year, if the Covered Employee arranges to make full contribution directly to the Plan during such leave;

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be

imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Continuation for Retirees. A Covered Employee who ceases Active Work because of an approved retirement under the terms and conditions outlined in the retirement language as identified in the District's Master Contract will nevertheless be considered as employed provided that full contribution continues to be made by the retiree to the Plan during such retirement.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to one hundred two percent (102%) of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The last date of the month that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)

(3) The last date of the month a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)

(4) On the last date of the month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

SECTION III
SCHEDULE OF BENEFITS

BENEFITS FOR COVERED SERVICES

All benefits described in this Schedule are subject to the exclusions, limitations and other provisions of the Plan, described more fully herein including, but not limited to, the Claim Administrator's determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Please see the Medical Management and Medical Benefits sections in this booklet for details.

The Plan is a plan which contains a Participating Provider Organization.

PPO name:	**DAKOTACARE Administrative Services, Inc.**
Address:	**2600 West 49th Street**
	Sioux Falls, SD 57117-7406
Telephone:	**1-800-325-5598**
Website:	**www.dakotacare.com**

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used.

Health Services Rendered By Non-Participating Providers

Emergency Health Services

The Plan will pay those Medically Necessary services and supplies for Covered Services, for emergency health services rendered to a Covered Person by Non-Participating Providers, subject to the terms and conditions and to all limitations and exclusions of this Plan.

The emergency health services required must be: 1) of such an immediate nature that a prudent layperson would reasonably believe that use of a Participating Provider would result in a delay that would worsen the emergency; or 2) if a provision of federal, state or local law requires the use

of a specific provider; or 3) provided under circumstances under which the Covered Person is unable, due to his or her condition, to request treatment at a location where the services of a Participating Provider would be available.

The Covered Person must notify DAKOTACARE Administrative Services, Inc. within one (1) business day after emergency health services are initially provided by a Non-Participating Provider, or as soon thereafter as is reasonably possible. Full details for the emergency health services rendered shall be made available to DAKOTACARE Administrative Services, Inc. at its request. Continuation of care through the Non-Participating Provider after initial emergency care is rendered shall require the authorization of DAKOTACARE Administrative Services, Inc.

If the Covered Person is hospitalized with a Non-Participating Provider, he or she may be transferred to a Participating Provider, upon request by DAKOTACARE Administrative Services, Inc., as soon as, in the opinion of the DAKOTACARE Administrative Services, Inc.'s Medical Director, it is medically appropriate to do so.

Eligible expenses for emergency health services are the Maximum Allowable less applicable Copayments, Deductibles and Coinsurance, and any charge made by the provider in excess of the Maximum Allowable. The health services must be ordered by a Physician and are subject to the limitations, exclusions, and other provisions of this Plan.

Non-Emergency Health Services

Preauthorization of certain Medical Management Services: 1-800-658-5508.

Subject to the conditions below, the Plan will pay those Medically Necessary services and supplies rendered by a Non-Participating Provider for non-emergency services, subject to the following:

- The Covered Person must call to preauthorize in advance of services being rendered.

- Such services shall be subject to all limitations and exclusions of this Plan.

- The Covered Person shall pay any Copayment, Deductible, and Coinsurance for which the Covered Person would otherwise be responsible if the service or supply were rendered by a Participating Provider.

- The Plan shall pay the lesser of the Non-Participating Reimbursement amount or the Maximum Allowable, as determined by DAKOTACARE Administrative Services, Inc., less any applicable Copayment amount after credit is given for payment of any applicable Deductible.

- The Covered Person shall pay to the provider of the service the Non-Participating Reimbursement amount or Maximum Allowable, any applicable Copayment amount, and any charge made by the provider in excess of the Maximum Allowable.

If a Participating Provider recommends a Covered Person must receive Medically Necessary services and supplies from a Non-Participating Provider and DAKOTACARE Administrative Services, Inc. authorizes the referral to a Non-Participating Provider, the amount payable by the Plan for Medically Necessary services and supplies shall be determined as follows:

- Such services shall be subject to all limitations and exclusions of this Plan.

- The Covered Person shall pay any Copayment, Deductible, and Coinsurance for which the Covered Person would otherwise be responsible if the service or supply were rendered by a Participating Provider.

- The Plan shall pay the lesser of the billed charge or the Maximum Allowable, as determined by DAKOTACARE Administrative Services, Inc., less any applicable Copayment, Deductible, and Coinsurance amount.

- The Covered Person shall pay to the provider of the service any applicable Copayment, Deductible, and Coinsurance amount and any charge made by the provider in excess of the Maximum Allowable.

Deductibles/Coinsurance payable by Plan Participants

Deductibles/Coinsurance are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Plan Benefit Year per Covered Person. Typically, there is one (1) Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new Deductible amount is required.

Expenses incurred during the months of October, November and December which were used in whole or in part to satisfy the deductible may be used again to satisfy the Deductible in the succeeding calendar year. Deductibles accrue toward the one hundred percent (100%) maximum out-of-pocket payment.

Coinsurance is a specified dollar amount expressed as a percentage of the allowance for covered services for which each Covered Person is billed for services and is responsible for payment.

OPTION A

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PLAN BENEFIT YEAR MAXIMUM BENEFIT FOR ALL ESSENTIAL HEALTH BENEFITS	$1,000,000	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Benefit Year maximum is 60 days total which may be split between Participating and Non-Participating Providers.		
DEDUCTIBLE, PER PLAN BENEFIT YEAR		
Per Covered Person	$500	$500
Per Family Unit	$1,000	$1,000
The Plan Benefit Year Deductible is waived for the following Covered Charges: -- Preventative Care		
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN BENEFIT YEAR (Including Deductible)		
Per Covered Person	$1,500	$2,500
Per Family Unit	$3,000	$5,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Benefit Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Non-Participating Provider penalties		

OPTION A

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
COVERED SERVICES		
Hospital Services		
Room and Board	85% after Deductible the semiprivate room rate 365 days per period of confinement	70% after Deductible the semiprivate room rate 365 days per period of confinement
Intensive Care Unit	85% after Deductible Hospital's ICU Charge	70% after Deductible Hospital's ICU Charge
Emergency Room	85% after Deductible	70% after Deductible
Skilled Nursing Facility	85% after Deductible the facility's semiprivate room rate 60 days Plan Benefit Year maximum	70% after Deductible the facility's semiprivate room rate 60 days Plan Benefit Year maximum
Physician Services		
Inpatient visits	85% after Deductible	70% after Deductible
Office visits	85% after Deductible	70% after Deductible
Surgery	85% after Deductible	70% after Deductible
Allergy testing	85% after Deductible	70% after Deductible
Allergy serum and injections	85% after Deductible	70% after Deductible
Home Health Care	85% after Deductible	70% after Deductible
Outpatient Private Duty Nursing	85% after Deductible	70% after Deductible
Injectable Medications	85% after Deductible	70% after Deductible

OPTION A

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Hospice Care	85% after Deductible	70% after Deductible
Ambulance Service		
Ground Transportation Per Trip	85% after Deductible $1,500	85% after Deductible $1,500
Air Transportation Per Trip	85% after Deductible $3,500	85% after Deductible $3,500
Base Rate for Air Transportation Per Trip	85% after Deductible $4,500	85% after Deductible $4,500
Wig After Chemotherapy	85% after Deductible Limited to 1 per Lifetime	70% after Deductible Limited to 1 per Lifetime
Jaw Joint/TMJ	85% after Deductible	70% after Deductible
Occupational Therapy	85% after Deductible	70% after Deductible
Speech Therapy	85% after Deductible	70% after Deductible
Physical Therapy	85% after Deductible	70% after Deductible
Durable Medical Equipment	85% after Deductible	70% after Deductible
Inpatient Rehabilitation	85% after Deductible	70% after Deductible
Spinal Manipulation Chiropractic	85% after Deductible	70% after Deductible

OPTION A

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Mental Disorders		
Inpatient	85% after Deductible	70% after Deductible
Partial Hospitalization	Every two Partial Hospitalization days is equivalent to one inpatient hospitalization day.	Every two Partial Hospitalization days is equivalent to one inpatient hospitalization day.
Outpatient	85% after Deductible	70% after Deductible
Substance Abuse		
Inpatient	85% after Deductible	70% after Deductible
Outpatient	85% after Deductible	70% after Deductible
Preventative Health Services	100%	70% after Deductible
Organ Transplants	100% after Deductible transportation/lodging/ meal expenses of individual accompanying donor recipient limited to $250 per day/$8,000 per transplant maximum	No coverage
Pregnancy	85% after Deductible	70% after Deductible
Morbid Obesity	50% after Deductible Maximum allowable of $12,500	No Coverage
Prescription Drugs	See Section IX – Pages 77-80	

OPTION B

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PLAN BENEFIT YEAR MAXIMUM BENEFIT FOR ALL ESSENTIAL HEALTH BENEFITS	$1,000,000	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Benefit Year maximum is 60 days total which may be split between Participating and Non-Participating Providers.		
DEDUCTIBLE, PER PLAN BENEFIT YEAR		
Per Covered Person	$1,000	$1,000
Per Family Unit	$2,000	$2,000
The Plan Benefit Year Deductible is waived for the following Covered Charges: -- Preventative Care		
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN BENEFIT YEAR (Including Deductible)		
Per Covered Person	$2,500	$4,000
Per Family Unit	$5,000	$8,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Benefit Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. – Cost containment penalties – Non-Participating Provider penalties		

OPTION B

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
COVERED SERVICES		
Hospital Services		
Room and Board	85% after Deductible the semiprivate room rate 365 days per period of confinement	70% after Deductible the semiprivate room rate 365 days per period of confinement
Intensive Care Unit	85% after Deductible Hospital's ICU Charge	70% after Deductible Hospital's ICU Charge
Emergency Room	85% after Deductible	70% after Deductible
Skilled Nursing Facility	85% after Deductible the facility's semiprivate room rate 60 days Plan Benefit Year maximum	70% after Deductible the facility's semiprivate room rate 60 days Plan Benefit Year maximum
Physician Services		
Inpatient visits	85% after Deductible	70% after Deductible
Office visits	85% after Deductible	70% after Deductible
Surgery	85% after Deductible	70% after Deductible
Allergy testing	85% after Deductible	70% after Deductible
Allergy serum and injections	85% after Deductible	70% after Deductible
Home Health Care	85% after Deductible	70% after Deductible
Outpatient Private Duty Nursing	85% after Deductible	70% after Deductible

OPTION B

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Injectable Medications	85% after Deductible	70% after Deductible
Hospice Care	85% after Deductible	70% after Deductible
Ambulance Service		
Ground Transportation Per Trip	85% after Deductible $1,500	85% after Deductible $1,500
Air Transportation Per Trip	85% after Deductible $3,500	85% after Deductible $3,500
Base Rate for Air Transportation Per Trip	85% after Deductible $4,500	85% after Deductible $4,500
Wig After Chemotherapy	85% after Deductible Limited to 1 per Lifetime	70% after Deductible Limited to 1 per Lifetime
Jaw Joint/TMJ	85% after Deductible	70% after Deductible
Occupational Therapy	85% after Deductible	70% after Deductible
Speech Therapy	85% after Deductible	70% after Deductible
Physical Therapy	85% after Deductible	70% after Deductible
Durable Medical Equipment	85% after Deductible	70% after Deductible
Inpatient Rehabilitation	85% after Deductible	70% after Deductible
Spinal Manipulation Chiropractic	85% after Deductible	70% after Deductible

OPTION B

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Mental Disorders		
Inpatient	85% after Deductible	70% after Deductible
Partial Hospitalization	Every two Partial Hospitalization days is equivalent to one inpatient hospitalization day.	Every two Partial Hospitalization days is equivalent to one inpatient hospitalization day.
Outpatient	85% after Deductible	70% after Deductible
Substance Abuse		
Inpatient	85% after Deductible	70% after Deductible
Outpatient	85% after Deductible	70% after Deductible
Preventive Health Services	100%	70% after Deductible
Organ Transplants	100% after Deductible transportation/lodging/ meal expenses of individual accompanying donor recipient limited to $250 per day/$8,000 per transplant maximum	No coverage
Pregnancy	85% after Deductible	70% after Deductible
Morbid Obesity	50% after Deductible Maximum allowable of $12,500	No coverage
Prescription Drugs	See Section IX - Pages 77-80	

SECTION IV
MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Benefit Year a Covered Person must meet the Deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Benefit Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that Plan Benefit Year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate Deductibles for treatment of injuries incurred in this accident; instead, only one Deductible for the Plan Benefit Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Plan Benefit Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any Copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Benefit Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at one hundred percent (100%) (except for the charges excluded) for the rest of the Plan Benefit Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at one hundred percent (100%) (except for the charges excluded) for the rest of the Plan Benefit Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED SERVICES

A Covered Person shall be entitled to Medically Necessary services and supplies, if provided by or under the direction of a Physician. These services are subject to: 1) the limitations, exclusions, and other provisions of the Plan, 2) payment by the Covered Person of any applicable Copayment, Deductible, and Coinsurance specified for any service, and 3) in certain enumerated instances, preauthorization by DAKOTACARE Administrative Services, Inc. Certain benefits are available only at facilities designated by DAKOTACARE Administrative Services, Inc. to provide those benefits.

(1) Local Medically Necessary licensed land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Claim Administrator finds a longer trip was Medically Necessary.

(2) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(3) The initial purchase, fitting and repair of **appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(4) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered under the supervision of a Physician and the benefits shall be limited to Covered Persons who (1) have completed a documented diagnosis of myocardial infarction within the preceding twelve (12) months; or (2) have had recent coronary bypass surgery and/or (3) have stable angina pectoris. Requests for cardiac rehabilitation sessions for conditions other than those listed above must be preauthorized by DAKOTACARE Administrative Services, Inc.

(5) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(6) **Dental Services** covered under Medical Benefits. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth not incidental to the fitting or continued use of dentures.

Emergency repair if due to accidental bodily Injury to sound natural teeth which occurred while covered under this Plan, excluding any Injury caused by chewing or dentures, and such services are rendered within three (3) months of such Injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. Services must be rendered within three (3) months of such Injury.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(7) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan and preauthorized by DAKOTACARE Administrative Services, Inc.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

(8) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months and placed the person under a Hospice Care Plan and preauthorized by DAKOTACARE Administrative Services, Inc.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(9) **Hospital Care.** The medical services and supplies furnished by a Hospital if prescribed or approved by a Physician and upon preauthorization by DAKOTACARE Administrative Services, Inc. Covered charges for room and board will be payable as shown in the Schedule of Benefits.

(a) Inpatient Services

(i) Room and Board.

(ii) Confinement in an Acute Care Hospital on a semi-private accommodation basis as stated in the Schedule of Benefits.

(iii) Other Inpatient Services and Supplies Services and supplies other than Room and Board provided in an Acute Care Hospital or while the Covered Person is confined.

These services must be preauthorized by DAKOTACARE Administrative Services, Inc.

(b) Emergency Services and/or Outpatient Services and Supplies

(i) Services and Supplies provided on an outpatient basis by an Acute Care Hospital, Emergency Care Center, Ambulatory Surgical Center or a Birthing Center.

(10) **Injectable medications.** Charges for injectable medications including self injectable medications, except for insulin.

(11) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint (TMJ) Syndrome**. Must be preauthorized by DAKOTACARE Administrative Services, Inc.

(12) **Laboratory studies** in accordance with accepted medical practice.

(13) **Mental Health and Substance Use Disorder Services.**

(a) Coverage is provided for Medically Necessary Biologically Based Mental Illnesses, defined by SDCL 58-18-80 as schizophrenia and other psychotic disorders, bipolar disorder, major depression, obsessive-compulsive disorder, and certain other non-biologically based mental illness.

(i) Outpatient psychiatric diagnostic and therapeutic services, provided by a Physician, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor – Mental Health, or Licensed Marriage and Family Therapist.

(ii) Medically Necessary inpatient services (including semi-private accommodations) while confined in a Hospital, Psychiatric Hospital, or other health care facility or program, under the direction of a Physician. These services require Preauthorization by DAKOTACARE Administrative Services, Inc.

(iii) Medically Necessary Partial Hospital Care in a Hospital, Psychiatric Hospital, or other health care facility under the direction of a Physician. The utilization of two (2) Partial Hospital Care days shall be considered as the equivalent of one (1) day of inpatient care. Partial Hospital Care requires Preauthorization by DAKOTACARE Administrative Services, Inc. and shall be available only at Hospitals or other participating health care facilities designated by DAKOTACARE Administrative Services, Inc.

(b) Coverage is provided for Medically Necessary inpatient and outpatient services and supplies provided for the treatment of dependent substance use disorders at a Hospital or Substance Abuse Treatment Center.

Where it is determined that a Covered Person's substance use disorder treatment plan does not medically necessitate the entire course of treatment be provided on an inpatient basis and the Covered Person will benefit from a combination of treatment at a Hospital or substance Abuse Treatment Center inpatient facility and outpatient treatment facility, DAKOTACARE Administrative Services, Inc. may develop and institute a combination inpatient-outpatient facility and outpatient treatment program.

Prior to benefits being available, the services must be approved by a Physician and the Covered Person must receive Preauthorization from DAKOTACARE Administrative Services, Inc.

(c) Outpatient psychiatric, diagnostic and therapeutic services provided by a psychiatrist or licensed psychologist.

(14) Multiple Surgeries; Assistant Surgeries.

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed during the same surgical setting, payment shall be made for only the primary surgical procedure plus fifty percent (50%) of the Maximum Allowable Physician's fee for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) if multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Physician's fee for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable for that procedure; and

(b) Charges for an **assistant surgeon** will be a covered expense if an assistant surgeon is Medically Necessary. A Non-Participating assistant surgeon's covered charge will not exceed twenty percent (20%) of the surgeon's Maximum Allowable Physician's fee.

(15) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Inpatient occupational therapy services must be preauthorized by DAKOTACARE Administrative Services, Inc.

(16) **Organ transplant** limits. Organ Transplant Services and expenses incurred within the transplant benefit period as defined below. These services must be preauthorized by DAKOTACARE Administrative Services, Inc. and shall be available only at Hospitals designated by DAKOTACARE Administrative Services, Inc.

(a) Health services directly related to the transplanting of a natural kidney, kidney/pancreas, cornea, liver, heart, heart/lung, lung, and bone marrow (allogeneic and autologous) and stem cell transplants for certain conditions.

(b) The surgical, storage, and transportation costs incurred or directly related to the donation of the organ used in an organ transplant procedure. Donor coverage maximums are outlined in the Schedule of Benefits.

(c) The reasonable transportation costs to and from the site of the organ transplant procedure for the organ transplant recipient for the organ transplant procedure only.

(d) Associated Travel Expenses related to a Covered Transplant Procedure:

When the Covered Person receiving the transplant resides more than fifty (50) miles from the transplant site, Associated Travel Expenses will be covered under the plan. Associated Travel Expenses shall include:

(i) commercial transportation to and from the site of the transplant for the Covered Person receiving the transplant and one (1) companion; and

(ii) reasonable and customary lodging and meal costs incurred by the Covered Person and one (1) companion. Reasonable and customary lodging and meal costs are limited to $250 per day for the Covered Person and one (1) companion.

Transportation, lodging and meal costs are limited to an aggregate maximum of $8,000 per transplant episode for the Covered Person and one (1) companion.

Access Requirements:
DAKOTACARE Administrative Services, Inc. requires all transplants be preauthorized prior to receiving any services, including evaluation. It is the Participant's responsibility to obtain preauthorization for all transplant-related services. Failure to obtain preauthorization for any transplant-related services will result in non-coverage of benefits. All transplant-related services shall be available only at designated transplant facilities. The medical criteria for the type of approved transplant will be applied and each potential transplant must be deemed by DAKOTACARE Administrative Services, Inc. to be Medically Necessary and appropriate for the medical condition for which the transplant is proposed.

Approved Transplant Services:
Services and supplies for transplant-related services, when ordered by a Participating Physician, provided at or arranged by a designated transplant facility. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing and ancillary services rendered during the benefit period. Unless otherwise excluded in the "Plan Exclusions" Section coverage is provided for cornea, kidney, kidney/pancreas, liver, heart, heart/lung, lung and bone marrow (allogeneic and autologous) and stem cell transplants for certain conditions, when such transplants are Medically Necessary, medically appropriate and rendered in a designated transplant facility in accordance with DAKOTACARE Administrative Services, Inc. guidelines for transplantation health services. The Participant should contact DAKOTACARE Administrative Services, Inc. for information on designated transplant facilities and guidelines on transplantation.

Benefit Period:
The period of time from the date the Participant receives preauthorization and has an initial evaluation for the transplant procedure until the earliest of (a) one (1) year from the date the transplant procedure was actually performed; or (b) the date of the Participant's death. The total benefit per Participant for all benefits under this coverage shall not exceed the maximums set forth in the Schedule of Benefits.

Benefits under this organ transplant coverage do not include services or supplies related to any transplant of inter-species organs or xenograft or any transplant involving a mechanical organ.

(17) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(18) **Pregnancy Care.** Medical and Hospital Services, including prenatal and postnatal care provided under the direction of a Physician.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable).

(19) **Prescription Drugs** (as defined).

(20) **Preventive Health Services.** Medically Necessary Preventive Health Services provided by a Participating Provider. Covered preventive health services provided by a Participating Provider are not subject to Deductible, Coinsurance, and Copayment. Covered Person is responsible for applicable Copayment, Deductible, and Coinsurance for covered preventive health services rendered by a Non-Participating Provider.

The services covered under the preventive health services coverage provision are, at a minimum, compliant with: (1) evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); (2) immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (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); (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

These services will be covered according to the timing and intervals defined by these agencies, and may include, but are not limited to:

- Cervical Cancer Screening
- Breast Cancer Screening
- Prostate Cancer Screening

- Colon/Rectal Cancer Screening
- Immunizations
- Preventive Care and Screenings for Infants, Children, Adolescents, and Women
- Diagnostic Testing
- Laboratory Tests
- X-Ray Examinations

Visit www.dakotacare.com for a complete list of available preventive health services.

(21) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary and preauthorized by DAKOTACARE Administrative Services, Inc. or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and preauthorized by DAKOTACARE Administrative Services, Inc. and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a twenty-four (24) hour shift basis is not covered.

(22) **Prosthetic and Durable Medical Equipment Expenses** if prescribed or approved by a Physician and upon preauthorization by DAKOTACARE Administrative Services, Inc.

(a) The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts.

(b) Replacement of prosthetic devices which wear out or are outgrown (duplicates or replacements for lost articles are not covered).

(c) The rental (not to exceed the total cost of purchase) or purchase, at the option of DAKOTACARE Administrative Services, Inc. of Durable Medical Equipment, not including motorized equipment, motorized carts or other motorized vehicles, or for the conversion of motorized equipment, motorized carts, or other motorized vehicles.

(23) **Reconstructive Surgery.** Correction of abnormal congenital conditions, those necessitated by an accident occurring during the time when the Covered Person was covered by the Plan or reconstructive mammoplasties will be considered Covered Charges.

Mammoplasty coverage will include reimbursement for:

(a) reconstruction of the breast on which a mastectomy has been performed,

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(24) **Rehabilitation Services.** Confinement in a Rehabilitation Facility on a semi-private accommodation basis as set forth in the Schedule of Benefits. These services must be preauthorized.

(25) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if prescribed or approved by a Physician and upon preauthorization by DAKOTACARE Administrative Services, Inc. and when:

(a) the patient is confined as a bed patient in the facility;

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

(26) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Inpatient speech therapy services must be preauthorized by DAKOTACARE Administrative Services, Inc.

(27) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(28) **Sterilization** procedures.

(29) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(30) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for **Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

Charges for covered routine nursery care will be applied toward the Plan of the covered Dependent.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable).

Charges for covered routine Physician care will be applied toward the Plan of the covered Dependent.

(31) Charges associated with the initial purchase of a **wig after chemotherapy**. Limited to one (1) per Lifetime.

(32) Diagnostic **x-rays** in accordance with accepted medical practice.

SECTION V
MEDICAL MANAGEMENT SERVICES

UTILIZATION REVIEW

Preauthorization

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Preauthorization of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

ADMISSIONS

- Surgical, nonsurgical (medical), and *maternity
- Skilled nursing
- Rehabilitation
- Hospice
- Transplant services
- Out-of-network services
- Observation services greater than two (2) days
- Mental health and chemical dependency, including partial

* Preauthorization is only required for stays which exceed the maximums outlined in The Newborns' and Mothers' Health Protection Act of 1996

OUTPATIENT

- Selected outpatient procedures
- Dental services
- Home health services, including home intravenous therapy, pain management, and hospice
- Ambulatory infusion
- Pulmonary Rehabilitation
- Cardiac Rehabilitation (over 24 visits)
- Transplant services
- Out-of-network services
- Chemical dependency
- Select Durable Medical Equipment
- Select Specialty Formulary drugs

NOTIFICATION ONLY

– Specialized Imaging

CT	PET
MRI	Cardiac Nuclear Imaging

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review of a course of treatment and discharge planning for release from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay, or use of other medical services, and will coordinate the appropriate plan of care with the attending Physician, Medical Care Facility and Covered Person. This plan of care will include the scheduled release or extension of the Medical Care Facility stay, transfer to a more appropriate level of care or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been preauthorized, the attending Physician must request the additional services or days.

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

When a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-participating Provider is used.

(a) Participating Providers
If you have a service that requires preauthorization, your Physician will notify DAKOTACARE Administrative Services, Inc.

(b) Non-Participating Providers
If the services are provided by a non-participating provider, it is the Covered Person's responsibility to contact DAKOTACARE Administrative Services, Inc. for preauthorization. Preauthorization means calling DAKOTACARE

Administrative Services, Inc. prior to the scheduled service or within one (1) business day after Emergency Health Services are initially provided. Emergency Health Services provided on a weekend or holiday, DAKOTACARE Administrative Services, Inc. must be notified by the next business day.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 25% to a maximum of $250.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Situations in which Case Management may occur shall include, but not be limited to:

(1) Conditions which are known to or which may, in the judgment of DAKOTACARE Administrative Services, Inc., exceed the utilization guidelines adopted by DAKOTACARE Administrative Services, Inc.

(2) Conditions which are generating or are known to generate ongoing and high costs in relations to alternative cost-effective health care delivery mechanisms.

(3) Conditions which are known to require extensive care and treatment.

The case manager will coordinate and implement the Case Management program by maintaining communication with the health care provider and the Covered Person to develop and access an appropriate treatment plan, to explore alternatives for the care and treatment of the Covered Person, and to determine the benefits available to the Covered Person based on the Plan.

DAKOTACARE Administrative Services, Inc. reserves the right to develop and institute appropriate and cost-effective treatment plans for your care and treatment. The failure of a Covered Person to comply with an individual benefits management program developed by DAKOTACARE Administrative Services, Inc. may result in a limitation of health care benefits available to a Covered Person.

PREVENTION OF MEDICALLY HARMFUL USE OF SERVICES AND LIMITATIONS ON COVERAGE RELATED THERETO

If, upon a review of the medical services rendered a Covered Person, DAKOTACARE Administrative Services, Inc. determines a Covered Person is receiving health services or prescription medication in a manner which, in DAKOTACARE Administrative Services, Inc.'s opinion, is a harmful quantity or manner, with harmful frequency, or is not Medically Necessary , the Covered Person may be required by DAKOTACARE Administrative Services, Inc. to select a single Participating Physician, Participating Hospital, or other Participating Provider for the individual management and coordination of all future health services. If a Covered Person fails to voluntarily select a coordinating Participating Provider within thirty-one (31) days of written notice by the Plan of the need to do so, the Plan shall designate a coordinating DAKOTACARE Administrative Services, Inc. Participating Provider for that Covered Person. Following selection or designation of a coordinating Participating Physician for a Covered Person, coverage for covered health services shall be contingent upon the services being provided by, or through written referral of, the coordinating DAKOTACARE Administrative Services, Inc. Participating Physician for that Covered Person, except Emergency Health Services.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECTION VI
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee. An Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

ADEA Employer. An Employer which:

(1) is subject to the U.S. Age Discrimination in Employment Act (ADEA); and

(2) has twenty (20) or more Participants each working day in twenty (20) or more calendar weeks during the current or preceding Calendar Year.

Alternate Recipient. Any child of a Participant who is recognized under a medical child support order as having a right to enroll in a group health Plan with respect to the Participant.

Ambulatory Surgical Center. A licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.s) and does not provide for overnight stays.

Amendment. A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

Approved Transplant Services. Medically Necessary health services and supplies rendered at a Designated Transplant Facility during the Benefit Period which are: (1) related to transplantation, and (2) authorized by means of approval in writing by DAKOTACARE Administrative Services, Inc. (DAS) prior to the delivery of any services. Such services shall include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services rendered during the Benefit Period.

Assistance Eligible Individual. Any Qualified Beneficiary who elects COBRA continuation coverage, and has satisfied all of the following conditions:

- The qualifying event occurred at any time during the period that begins with September 1, 2008, and ends with May 31, 2010, and the Qualified Beneficiary was eligible for COBRA Continuation Coverage during this period;

- The covered Employee or Qualified Beneficiary must elect COBRA or applicable state continuation coverage;

- The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered Employee's employment and occurred during such period; and

- The covered Employee must have had a modified adjusted gross income of less than $145,000, if single, or $290,000, if married filing jointly, for each tax year in which the subsidy is received. Note that the available COBRA subsidy will be reduced for years in which the covered Employee's gross income exceeds $125,000 (or $250,000 for joint returns).

Benefit Percentage. That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket expenses in excess of the annual Deductible which are to be paid by the Covered Person.

Benefit Period. A time of one (1) year as shown on the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

(1) The last day of the one (1) year period so established; or

(2) The day the maximum lifetime benefit applicable to the covered Person becomes payable; or

(3) The day the Covered Person ceases to be covered for Medical Expense Benefits.

Birthing Center. Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name. A trade name medication.

Calendar Year. A period of time commencing on January 1 and ending on December 31 of the same given year.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance. A specified dollar amount calculated using a fixed percentage of the allowance for covered services for which each Covered Person is responsible for payment.

Cosmetic Procedure. A procedure/service performed solely for the improvement of a person's appearance rather than for the improvement or restoration of bodily function.

Covered Person. An Employee or Dependent who is covered under this Plan.

Creditable Coverage. Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or IHS.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care. Care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible. A specified dollar amount of covered services that must be incurred by a Covered Person during a Plan Benefit Year before benefits become payable under this Plan.

Dentist. A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent. The Participant's Legal Spouse, or unmarried children, which shall include natural children, stepchildren, and adopted children, who:

(1) Have not passed their twenty-sixth (26th) birthday; or

(2) Are Totally Disabled, either physically or mentally, provided such total disability has been continuous since the child's twenty-sixth (26^{th}) birthday. Total disability, as used herein, means being unable to engage in any gainful employment; or

(3) Are an Alternate Recipient under a qualified medical child support order as required by the Employee Retirement Income Security Act (ERISA) as amended by the Omnibus Budget Reconciliation Act of 1993.

Dependent Coverage. Services rendered to an Eligible Dependent while such person is covered under the terms of this Plan.

District. Watertown School District #14-4 is the employer which has established the self-funded group medical and dental benefit plan.

Drug Formulary. A compilation of therapeutically effective prescription drugs that are accepted by DAKOTACARE Administrative Services, Inc. (DAS) for treatment of Covered Persons. Within a particular therapeutic category, some, but not all brand-name and generic drugs may be included.

Durable Medical Equipment. Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee. A person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship, or Retired from the District in accordance with the retirement language.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In

that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employer. Watertown School District #14-4.

Enrollment Date. The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational. Services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Claim Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Claim Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Claim Administrator will be final and binding on the Plan. The Claim Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit. The covered Employee and the family members who are covered as Dependents under the Plan.

Generic Prescription Medication means a medication which is a chemically equivalent copy designed from a brand name drug whose patent has expired, requires a prescription, is marketed under its chemical name, is manufactured by more than two (2) generic manufacturers and is offered at a significantly reduced cost as compared to the brand product.

Genetic Information. Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency. An organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan. Must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies. A program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify that the proper treatment of the Illness or Injury would require continued confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice Agency. An organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan. A plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies. Those provided through a Hospice Agency and under a Hospice Care Plan.

Hospice Unit. A facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan.

Hospital. An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises twenty-four (24)-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; has a Physician in regular attendance; continuously provides twenty-four (24)-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness. A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury. An accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit. Defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically ill; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee. A Plan Participant who enrolls under the Plan other than during the first thirty (30) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime. A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. If multiple plan options are offered, the Lifetime maximum in one plan or option applies across all plans or options offered by the Employer. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maximum Allowable. The maximum reimbursement in dollars, as determined by DAKOTACARE Administrative Services, Inc., which will be paid for covered health services or supplies less any applicable Copayment, Deductible, and Coinsurance for which the Covered Person is responsible for payment.

Medical Care Facility. A Hospital, a facility that treats one (1) or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary. Care and treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claim Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare. The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder. Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity. A diagnosed condition in which the body mass index is equal to or greater than forty (40).

No-Fault Auto Insurance. The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Out-of-Pocket Maximum. The portion of payments for health services which is the responsibility of the Covered Person, which shall include Copayments and Deductibles. Copays and the cost of services which are not covered due to their being subject to Limitations or Exclusions do not apply toward the Out-of-Pocket Maximum.

Outpatient Care and/or Services. Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization. An outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than twenty-four (24) hours, but more than four (4) hours, a day and no charge is made for room and board.

Pharmacy. A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician. A doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes Physician's assistants, Certified Nurse Practitioners, and registered nurse-midwives, when working directly for a doctor of medicine. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry, optometrists, and chiropractors are deemed to be Physicians when acting within the scope of their license for services covered by this Plan. Registered Physical, Occupational, Respiratory, and Speech Therapists, Psychologists, and Social Workers licensed under state law when providing a covered service will be covered under this definition.

Plan. The Employee Benefit Trust, which is a benefits plan for certain Employees of Watertown School District #14-4 and is described in this document.

Plan Participant. Any Employee or Dependent who is covered under this Plan.

Plan Benefit Year. January 1st through December 31st of the same year.

Preauthorization. The process DAKOTACARE Administrative Services, Inc. (DAS) employs to ensure it has been notified before services are provided of an admission or provision of service in order that DAKOTACARE Administrative Services, Inc. (DAS) can determine the medical necessity of the admission or service on behalf of the Plan.

Pre-Existing Condition. A condition for which medical advice, diagnosis, care or treatment was recommended or received within ninety (90) days prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

The Pre-Existing Condition does not apply to Pregnancy or to any Covered Person that has not yet reached age nineteen (19).

Pregnancy. Childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug. Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes,

but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Rescission: A cancellation or discontinuance of coverage that has retroactive effect.

Sickness. A person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility. An institution, which is Medicare approved or licensed as a Skilled Nursing Facility by the South Dakota Department of Health, and is not, other than incidentally, a place for rest, the aged, the treatment of pulmonary tuberculosis, or the treatment of nervous or Mental Disorders.

Spinal Manipulation/Chiropractic Care. Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Specialty Injectable Medications means medications administered on an outpatient basis under the direct supervision of medical personnel, such as in a Physician's office, Hospital, or an infusion center. Certain medications require preauthorization. A Covered Person may inquire regarding specific coverage for Specialty Injectable Medications. These services shall be available only when provided by a provider designated by DAKOTACARE Administrative Services, Inc.

Specialty Medications means scientifically engineered medications that are prescribed to patients with complex diseases that may include rheumatoid arthritis, growth deficiencies, multiple sclerosis or cancer. The medications tend to be the product of innovative technology, high cost, and require special handling and administration. Types of specialty medications may include but are not limited to, self-administered injectable drugs administered by the patient or patient's caregiver in a home setting; office-administered injectable drugs administered by a healthcare professional in a non-hospital setting, inhalation agents for non-cancer treatments, and high cost oral agents.

Substance Abuse. Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome. The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled). In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Customary Charge. A charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. The Claim Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

SECTION VII
PLAN EXCLUSIONS

Covered Services and Supplies to be paid do not include:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(3) **Blood.** All cost associated with blood storage services.

(4) **Common Life Stressors.** Services for disorders in which the main symptoms are caused by, or in response to, exposure to common life stressors of a non-medical origin; marital relationship problems, social, marital or occupational maladjustment; and gambling addiction.

(5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(6) **Cosmetic and Reconstructive Plastic Surgery.** Any services performed to change appearance or to reconstruct an external body part, including reconstructive or cosmetic surgery for psychological reasons or necessitated by congenital anomalies, panniculectomy or removal of excess skin following surgery for Morbid Obesity or any services made necessary due to complications as a result thereof except:

(a) those necessitated by an accident occurring during the time when the Covered Person was covered by this Plan;

(b) those necessitated by a mastectomy, including augmentation of a non-diseased breast.

(7) **Court Ordered.** Examination, treatment, or testing which is received pursuant to an order or judgment issued by a court, administrative, or regulatory body.

(8) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care, convalescent or sanatorial care.

(9) **Delinquency.** Services for disorders which involve delinquency or behavior such as defiance, disobedience, quarrelsomeness, aggression, tantrums, stealing, lying, teasing, bullying, or sexual misconduct, unless determined to be Medically Necessary.

(10) **Dental.** Removal, care, or alignment of any teeth or dental prosthesis, mouth conditions due to periodontal or periapical disease, or the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue, and all services incidental thereto, unless otherwise specified under the Plan.

(11) **Educational or vocational testing.** Services for educational, vocational testing, self-help training, bio-feedback services or training or counseling in life management skills.

(12) **Exercise programs.** Exercise programs for treatment of any condition, cardiac rehabilitation, occupational, speech, recreational, exercise, educational, massage therapy or auditory rehabilitation, or physical therapy which are not specified as covered under the Plan.

(13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(14) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting unless otherwise specified under the Plan.

(15) **Food.** Food, food supplements, or special diets and liquids unless provided in an inpatient Hospital setting, or provided for the treatment of Phenylketonuria (PKU).

(16) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, drugs or supplies.

(18) **Forms.** Charges associated with failure to keep a scheduled appointment, phone consultations, completion of claim forms, or return to work or school forms.

(19) **Genetic testing.** Services related to molecular genetic testing (specific gene identification) or related genetic counseling, except for purposes of determination of therapy.

(20) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(21) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for one (1) wig following chemotherapy.

(22) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids to include those surgically implanted, or exams for their fitting, unless such care is specifically covered in the Schedule of Benefits.

(23) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Illegal drugs or medications.** 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 resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(25) **Infertility.** Care, supplies, services and treatment for infertility including, but not limited to, artificial insemination, in-vitro fertilization, embryo transplants and storage, and procedures and testing designed to facilitate conception.

(26) **Maximum Allowable.** Charges in excess of the DAKOTACARE Administrative Services, Inc.'s Maximum Allowable.

(27) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(30) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(31) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Surgery for Morbid Obesity is subject to preauthorization by DAKOTACARE Administrative Services, Inc. and shall be covered only if the Covered Person has been continuously covered under the plan for twelve (12) consecutive months and is further limited to one (1) procedure per Lifetime while under this Plan, with the maximum allowable of $12,500.

(32) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment, and is covered by worker's compensation or similar law.

(33) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, dehumidifiers, orthotic devices or other such corrective footwear devices, automobiles, vans, motorized carts, or other motorized vehicles or for the conversion of an automobile, van, motorized cart, or other motorized vehicle, hot tubs, exercise equipment, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

(34) **Physicals.** Physical, psychiatric, or psychological examinations or testing, or vaccinations, immunizations, treatments, or testing for purposes of obtaining or maintaining employment, insurance, or relating to camp, school, or athletic physicals.

(35) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(36) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(37) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(38) **Residence.** Construction, remodeling, or the structural alteration of a residence to accommodate the access to, mobility in, or use of the residence.

(39) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or

Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(40) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(41) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(42) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(43) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary and authorized by DAKOTACARE Administrative Services, Inc.

(44) **Smoking cessation.** Charges for the treatment of nicotine use or addiction.

(45) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(46) **Surrogacy.** Any services provided to a Covered Person or Eligible Dependent who is the genetic mother, genetic father, surrogate mother or birth mother of any child who is the product of a surrogacy agreement or arrangement, or for any otherwise Eligible Dependent, associated in any manner with any type of surrogacy agreement or arrangement. Such agreements or arrangements shall include, but not be limited to, traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement, or gestational or invitrofertilization surrogacy. Services provided to a child who is legally adopted by a Covered Person are not subject to this exclusion.

(47) **Taxes.** State and municipal provider taxes applied to medical services or supplies.

(48) **Therapy.** Acupuncture, chelation therapy, immunoaugmentive therapy (IAT), thermography, joint reconstruction therapy, joint sclerotherapy, prototherapy, or ligamentous injections with sclerosing agents and kebiozen.

(49) **Transplants.** Transplanting any body organ or part with natural or mechanical substitution and any prepatory and post operative care that is not severable and distinct from the actual physical transplant in any meaningful sense.

Organ Transplant payments for treatments, procedures, devices, drugs or medicines which the Plan determines are experimental or investigational. This means that one or more of the following is true:

(a) The device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.

(b) Reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

(c) Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no payment is available for any:
(a) treatments, services, or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplants of non-human organs, cornea transplants or other transplants not listed in the Medical Expense Benefits.

(50) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(51) **Usual and Customary Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary Charge.

(52) **War.** Any loss that is due to a declared or undeclared act of war.

SECTION VIII
DENTAL BENEFITS

SCHEDULE OF DENTAL BENEFITS

DENTAL DEDUCTIBLE

Type I Services – None (0)

Type II and III Services have a combined $25 Deductible with a Family maximum of three (3) Deductibles met per Calendar Year.

Type IV Services – None (0)

DENTAL BENEFITS

Copayment	
Type I – Preventative	100%
Type II – Basic	80%
Type III – Major	50%
Calendar Year Maximum	$1,000
Orthodontia (adults covered)	
Deductible	None
Copayment	50%
Lifetime Benefit	$1,500

Type I Services (Preventative)

The Maximum Covered Expense for any Type I Service is 100% of the Reasonable and Customary Charge.

(1) Oral examinations

(2) Cleaning of teeth

(3) Fluoride applications for children

(4) Dental x-rays

(5) Space maintainers

(6) Sealant applications for children

Type II Services (Basic)

The Maximum Covered Expense for any Type II Service is 80% of the Reasonable and Customary Charge.

(1) Extractions

(2) Oral surgery

(3) Fillings, other than gold

(4) General anesthetics

(5) Periodontics

(6) Endodontics

(7) Emergency office visits

(8) Injections

(9) Consultations

Type III Services (Major)

The Maximum Covered Expense for any Type III Service is 50% of the Reasonable and Customary Charge.

(1) Inlays, onlays, gold fillings and crowns

(2) Dentures

(3) Bridgework

(4) Repairs

(5) Replacements

Type IV Services (Orthodontia)

The Maximum Covered Expense for any Type IV service is 50% of the Reasonable and Customary Charge.

Maximum Benefit (Type I, II and III Services)

Maximum $1,000 each Calendar Year for each covered Participant.

Maximum Lifetime Benefit (Type IV Services)

$1,500 for all treatment for each covered Participant.

Predetermination of Benefits

Expenses for covered services that exceed $350 require a predetermination of benefit from your dentist before procedures are performed.

DESCRIPTION OF DENTAL BENEFITS

Benefits. If you or your Dependent, while covered under this provision, incur expense for Covered Services, the Plan will pay a percentage of that expense. The Plan will pay up to the Maximum for each Covered Person. The Percentage Payable and Maximum for the Type(s) of Services for which you or your Dependent are covered are shown in the Schedule.

Covered Services.

(1) Type 1 Services:

(a) Routine oral examinations, two (2) per Calendar Year.

(b) Routine prophylaxis (cleaning and scaling of teeth) by a dentist or dental hygienist, but not more than two (2) per Calendar Year.

(c) Fluoride treatment by a dentist or dental hygienist to the teeth of a Dependent who is less than age eighteen (18), but not more than once per Calendar Year.

(d) Dental x-rays, but not more than:

(i) one (1) full-mouth series or x-rays in any period of thirty-six (36) consecutive months; and

(ii) four (4) supplemental bite-wing x-rays, but not more than two (2) per Calendar Year.

(e) Space maintainers that replace prematurely lost teeth for children under sixteen (16) years of age, including any adjustments more than six (6) months after installation (limited to initial application only.)

(f) Dental sealants applied to the first and second permanent molars, but only:

(i) for your Dependent who is age fifteen (15) or younger; and

(ii) when the teeth have not been treated with sealants for at least four (4) years.

(g) Tests and laboratory examinations.

(2) Type II Services:

(a) Extractions, including local anesthesia and routine postoperative care.

(b) Oral surgery, including local anesthesia and routine postoperative care.

(c) Amalgam, silicate, acrylic, synthetic porcelain and composite fillings restorations to restore diseased or accidental broken teeth (multiple restorations in one (1) surface will be considered as a single restoration).

(d) General anesthesia when Medically Necessary and administered in connection with oral or dental surgery.

(e) Periodontic procedures (procedures for treatment of the area around the tooth), including periodontal surgery (gingival curettage) will be limited to four quadrants in any period of twelve (12) consecutive months.

(f) Endodontic procedures (procedures, such as root canal work, used for the treatment of the dental pulp).

(g) Emergency treatment for the relief of dental pain. The Plan will pay when no other benefit, other than dental x-rays, is payable under the Plan.

(h) Injection of antibiotic drugs by the attending dentist.

(i) Professional consultation recommended by the attending dentist.

(3) Type III Services:

(a) Inlays, onlays, gold fillings or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration.

(b) Initial installation of partial or full removable dentures, including any adjustments more than six (6) months after installation.

(c) Initial installation of partial or full removable dentures, including inlays and crowns as abutments.

(d) Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one (1) relining in any period of twelve (12) consecutive months or one (1) rebasing in any period of thirty-six (36) consecutive months.

(e) Replacement of crowns, inlay or onlay restorations by new crowns, inlay or onlay restorations by new crowns, inlay or onlay restorations, but only if satisfactory evidence is presented that the existing crown, inlay or onlay restoration cannot be made serviceable and at least five (5) years have elapsed prior to its replacement or such replacement is required as a result of an accidental Injury.

(f) Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(i) The replacement or addition of teeth is required to replace one (1) or more natural teeth extracted while covered under this Plan;

(ii) The existing denture or bridgework cannot be made serviceable and at least five (5) years have elapsed prior to its replacement or such replacement is required as a result of an accidental Injury: or

(iii) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be considered a Covered Service.

(4) Type IV Services:

Orthodontic diagnostic procedures and treatment consisting of surgical therapy and appliance therapy (including related oral examinations, surgery and extractions) for all eligible Participants.

Orthodontic Service will be covered only to the extent that it is made in connection with an orthodontic procedure which is required by one (1) or more of the following conditions:

(a) Overbite or overjet of at least four millimeters.

(b) Maxillary and mandibular arches in either protrusive or retrusive relation of at least one (1) cusp.

(c) Cross-bite.

(d) An arch length discrepancy of more than four millimeters in either the maxillary or mandibular arch.

(e) Bimaxillary protrusion of ten (10) millimeters or more.

Conditions

(1) Except as otherwise specifically provided, the service must be performed by a dentist and includes any required supplies.

(2) Before the Plan will pay any benefits, the Plan may ask for:

(a) Supporting proofs or loss:

(b) Clinical reports;

(c) Charts; and

(d) X-rays.

(3) When there are two or more methods of treating a condition, expense for a covered dental service will be based upon the charges for the least expensive course of treatment.

(a) Which the dental profession recognizes to be adequate in accord with widely accepted standards of dental practice; and

(b) Which the Plan determines to be appropriate in view of the Covered Person's total current oral conditions.

Extended Benefits. The Dental Benefit is payable for Covered Services after termination of a Covered Person's coverage only under the following specified circumstances;

(1) In the case of appliances or modifications of appliances not related to an Orthodontic Service, if the master impression is taken by a dentist while coverage is in force under this Plan, benefits will be payable if the appliance is delivered or installed within sixty (60) days after termination of coverage.

(2) In the case of the crown, inlay, onlay or cast restoration, if the teeth are prepared while coverage is in force under this Plan, benefits will be payable if such crown, bridge, inlay, onlay or case restoration are installed within sixty (60) days after termination of coverage.

(3) In the case of root canal therapy, if the pulp chamber is opened while coverage is in force under this Plan, benefits will be payable if such root canal therapy is completed within sixty (60) days after termination of coverage.

(4) In the case of an Orthodontic Service commencing while coverage is in force under this Plan, benefits will be payable through the end of the month in which coverage terminates, based on a proration of the applicable quarterly installment.

EXCLUSIONS AND LIMITATIONS

Coverage under this Plan does not include:

(1) Any Preventative, Basic or Major procedures begun prior to the date a person becomes covered under the Plan are not covered. Orthodontic expenses for services incurred on or after the effective date of the Plan will be covered.

(2) Dental services furnished a Covered Person for cosmetic purposes unless necessitated by an accidental Injury. For the purpose of this limitation, veneers, facings or similar properties of crowns or pontics placed on or replacing teeth posterior to the second bicuspid and personalization and characterization of dentures shall always be considered cosmetic.

(3) Dental services furnished a Covered Person for dental care of a congenital or developmental malformation unless the dental services are performed in connection with an Orthodontic Service.

(4) Prosthetics, including bridges and crowns, started or underway prior to the date you or your Dependent became covered under this provision.

(5) Rebasing or relining of a denture less than six (6) months after the first placement, and not more than one (1) rebasing in a period of thirty-six (36) consecutive months or one (1) relining in any period of twelve (12) consecutive months.

(6) Charges for any duplicate prosthetic device or any other duplicate device or appliance, or charges for the replacement of a lost, missing or stolen prosthetic device or any other device or appliance.

(7) Replacement of existing dentures, crowns and fixed bridges which have not been in place for five (5) years or more from the initial placement date will not be covered.

(8) A new denture or bridgework if the existing denture or bridgework can be made serviceable and placement of bridges for teeth lost prior to being covered under the Plan will not be covered.

(9) Charges you or your Dependent are not required to pay, including charges for services furnished by any Hospital or organization which normally makes no charge if the patient has no Hospital, surgical, medical or dental insurance.

(10) Orthodontic care, treatment, services and supplies, except as provided under Covered Services.

(11) Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint.

(12) A dental service not furnished by a dentist.

(13) Charges for oral hygiene, a plaque control program, dietary instruction, completion of claim forms or charges for failure to keep a scheduled visit with a dentist.

(14) Charges for implantology or charges for services which are experimental in nature.

(15) Charges for overdentures, including root canal therapy and supportive restorations.

(16) Any expense paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Employer.

(17) Sealants (except as provided under part (f) of Type I Services).

(18) Any expense for which you or your Dependent are entitled to benefits under a Workers' Compensation or occupational disease law.

(19) Any expense which is in excess of the usual and customary charges.

(20) Any expense which results, whether you or your Dependent are sane or insane, from an intentionally self-inflicted Injury or sickness.

(21) Any expense which results from you or your Dependent's participation in a riot or in the commission of a crime.

(22) Any expense or charge for services or supplies which are provided or paid for by federal government or its agencies; except for:

(a) The Veterans Administration, when services are provided to veteran for a disability which is not service connected;

(b) a military Hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services; or

(c) a group dental plan established by a government for its own civilian employees and their Dependents.

(23) Any expense which results from an act of declared or undeclared war or armed aggression.

(24) Any expense:

(a) which is incurred while you or your Dependent are on active duty or training in the Armed Forces, National Guard or Reserves of any state or country, and

(b) for which any governmental body or its agencies are liable.

(25) Any treatment, service or supply unless it is shown under Covered Services.

SECTION IX
PRESCRIPTION DRUG BENEFITS
(Both Option A and B)

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. The administrator of the Pharmacy drug plan is named on the Covered Person's ID Card.

Copayments

The Copayment is applied to each covered Pharmacy drug or mail order drug charge. The Copayment amount is not a covered charge under the medical Plan. Copayment amounts are as shown in the Schedule of Benefits.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, reimbursement shall be limited to the Maximum Allowable. When a pharmacy that is not participating in the network is used, the Covered Person must file the claim directly with the pharmacy benefits manager listed on the Covered Person's ID card. A prescription drug claim form must be completed and is available from the Claim Administrator.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law.

(2) Compounded prescriptions.

(3) Insulin and other diabetic supplies when determined to be medically necessary (excluding alcohol wipes and glucose).

(4) Prenatal Vitamins without DHA.

(5) Niacin for the treatment of cholesterol.

Limits To This Benefit

(1) Prescription medications will be dispensed according to federal and state law provisions.

(2) Prescription medications will be limited to the defined Prescription Drug Benefit day supply or one quantity level limit per prescription.

(3) Additional cost of any prescription medication for which a brand-name medication is purchased when a generic is available, unless the brand-name medication is deemed medically necessary by a physician in which case the prescription will be covered as a brand name prescription medication at the brand name co-pay.

(4) Charges that exceed Usual, Customary, and Reasonable Charge, less any applicable Copayment, Deductible and Coinsurance when obtained at a Non-Participating Pharmacy.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Charges for the administration of a covered prescription medication, unless prior authorization is obtained prior to the administration of the medication. This exclusion does not apply to vaccines when vaccines are covered under the prescription drug benefit.

(2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(3) **Cosmetic Medications.** Medications utilized to change appearance or to reconstruct an external body part. Medications include, but are not limited to: hair loss medications, anti-wrinkle, hair removal agents, depigmentation agents, and photo-age skin products.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Durable Medical Equipment** including but not limited to devices that require a prescription. Diabetic supplies are included in this exclusion unless specifically listed as a Covered Prescription Drug.

(6) **Experimental/Investigational.** Medications which are determined to be Experimental or Investigational in nature, in research development, or are used in a manner not approved by the United States Food and Drug Administration, except for off-label use recognized for treatment of certain indicators by standard reference compendia.

(7) **Fluoride** products, including, but not limited to, pediatric and adult formulations.

(8) **Illegal.** Prescription medications obtained by illegal means.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Infertility Medications.** Medications utilized for the treatment of infertility.

(11) **Injectable Medications.** Medications that are not considered to be self-administered by the Covered Person or the Covered Person's caretaker. Determination of self-administration is evaluated by the DAKOTACARE Administrative Services, Inc. Pharmacy and Therapeutics (P&T) Committee.

(12) **Lost, Damaged, or Stolen Medications.** Medications that are lost, damaged, stolen, or used inappropriately including medications determined to be abused or otherwise misused.

(13) **Medical exclusions.** Charges that are excluded from coverage under Medical Plan Exclusions.

(14) **Medications** related to or treatment in connection with trans-sexual surgery, gender transformation, sexual dysfunction, or sexual inadequacy.

(15) **No charge.** Charges for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** Drugs or medicines that can legally be bought without a written prescription. This does not apply to injectable insulin.

(17) **Over the counter Medications.** Over the counter medications, prescription medications with an over the counter equivalent available including homeopathic medications (or combinations of these, whether or not they include a legend/prescription medication). This exclusion does not apply to insulin.

(18) **Refills.** Any refill for a prescription medication that exceeds the refill limit set forth by federal and/or state law.

(19) **Relative prescribed.** Medications prescribed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law; unless it is the only provider in the area provided that the provider is acting within the scope of his or her practice.

(20) **Serums, toxoids, and vaccines,** unless specifically listed as a covered prescription drug.

(21) **Substance Use Disorders.** Medications related to nondependent substance use disorders.

(22) **Tobacco Cessation. Medications to diagnose or treat tobacco addiction or** co-dependency treatment.

(23) **Vitamins,** except those defined as covered in Covered Prescription Drugs.

(24) **Worker's Compensation.** Medications paid by workers' compensation or similar law.

Retail Pharmacy Option

Generic Drugs

Copayment..... $10

Formulary Brand Name drugs

Copayment..... $20

Non-Formulary Brand Name drugs

Copayment..... $40

Supply Limit ..... 34 days or 100 units whichever is greater

[A ninety (90) day supply of oral contraceptives is covered for one (1) copayment.]

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order Pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Mail Order Prescription Drug Option

Generic Drugs

Copayment..... $10

Formulary Brand Name drugs

Copayment..... $40

Non-Formulary Brand Name drugs

Copayment..... $80

Supply Limit ..... 90 day

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. The administrator of the Pharmacy drug plan is named on the Covered Person's ID card. For additional information on your Pharmacy benefit contact the administrator of the Pharmacy drug plan at the Pharmacy benefits phone number listed on the Covered Person's ID card. Representatives are available to answer your question twenty-four (24) hours seven (7) days a week.

A member shall pay one hundred percent (100%) of the additional cost of any prescription medication for which a brand-name medication is purchased when the generic medication is available.

SECTION X
CLAIM PROCEDURES

You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

DAKOTACARE Administrative Services, Inc.
P.O. Box 7406
Sioux Falls, SD 57117-7406

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, or a form approved for use by the ADA, completed by the dentist, including:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including PPO network repricing information);
- The name of the Plan;
- The name of the covered employee; and
- The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures For All Claims

The procedures outlined below must be followed by covered persons to obtain payment of health benefits under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to the third party 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 summary plan description may be delegated to the third party administrator; provided, however, that the third party administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

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

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously

jeopardize the life or health of the covered person or the covered person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a covered person needs medical care for a condition which would seriously jeopardize his life, there is no need to contact the Plan for prior approval. The covered person should obtain such care without delay.

Further, if the Plan does not require the covered person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The covered person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

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

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

  - The covered person requests extension of the course of treatment beyond that which the Plan has approved.

  Since the Plan does not require the covered person to obtain approval of a medical service in an emergency or urgent care situation, then there is no need to contact the Plan to request an extension of a course of treatment in an urgent care situation. The covered person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- **Post-service Claims.** A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with DAKOTACARE Administrative Services, Inc. within twelve (12) months of the date charges for the services were incurred. Failure to file a claim within this time limit

will not invalidate the claim provided that the covered person submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond one year from the date the charges were incurred except in the case of legal incapacity of the covered person. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by DAKOTACARE Administrative Services, Inc. in accordance with the Plan's procedures.

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

Timing of Claim Decisions

The Plan 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:

- Pre-service Non-urgent Care Claims:

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

    - If the 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 5 days after receipt of the claim. The covered person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the

initial processing period), or by the date agreed to by the Plan and the covered person (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan is notifying the covered person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), 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.

  - Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Post-service Claims:

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

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

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

covered person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

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

Notification of an Adverse Benefit Determination

The Plan shall provide a covered person with a notice, either in writing or electronically, containing the following information:

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

- Specific reason(s) for a denial;

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

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the covered person's claim for benefits;

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

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the covered person, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, or a statement that such explanation will be provided to the covered person, free of charge, upon request.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the covered person believes the claim has been denied wrongly, the covered person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 30 days to appeal a second adverse benefit determination;

- Covered persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

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

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

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

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

- That a covered person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances.

(1) First Appeal Level

(a) Requirements for First Appeal

The covered person must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the covered person's appeal must be addressed as follows and mailed or faxed as follows:

DAKOTACARE Administrative Services, Inc.
PO Box 7406
Sioux Falls, SD 57117-7406

It shall be the responsibility of the covered person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/covered person;

- The employee/covered person's social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the covered person will lose the right to raise factual arguments and theories which support this claim if the covered person fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the covered person has which indicates that the covered person is entitled to benefits under the Plan.

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

(b) Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the covered person of the Plan's benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

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

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

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

(c) Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan shall provide a covered person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the summary plan description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, will be provided free of charge upon request;
- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures;
- A statement of the covered person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

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

(d) Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

(2) Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the covered person has 30 days to file a second appeal of the denial of benefits. The covered person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the covered person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the covered person's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

(3) Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator shall notify the covered person of the Plan's benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

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

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

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

(4) Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

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

- A description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

(5) Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Review

If, for any reason, the covered person does not receive a written response to the appeal within the appropriate time period set forth above, the covered person may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 30 days after the Plan's claim review procedures have been exhausted.**

External Review

When a covered person has exhausted the internal appeals process outlined above, the covered person has a right to have that decision reviewed by independent health care professionals who has no association with the Plan, the Plan Sponsor, or the Plan Administrator. If the adverse benefit

determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request for external review within **4 months** after receipt of a denial of benefits to the Office of the Insurance Commissioner, [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your Plan Administrator with any questions on your rights to external review.

Appointment of Authorized Representative

A covered person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a covered person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the covered person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the covered person's medical condition to act as the covered person's authorized representative without completion of this form. In the event a covered person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the covered person, unless the covered person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a physician of its own choosing examine any covered person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The covered person must comply with this requirement as a necessary condition to coverage.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased covered person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

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

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a covered person to the provider; 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.

Non-U.S. Providers

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

- Benefits may not be assigned to a non-U.S. provider;
- The covered person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;

- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

- Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person or dependent on whose behalf such payment was made.

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

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

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree 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-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. 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 a 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.

Medicaid Coverage

A covered person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such covered person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the covered person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

SECTION XI
COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total allowable expenses.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group and nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical care components of long-term care contracts, such as skilled nursing care;

(6) The medical benefits coverage in automobile no fault and traditional automobile fault type contracts;

(7) Medicare or other governmental benefits, as permitted by law, except for the medical assistance program. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program; and

(8) Medical Benefits coverage in Homeowner's and Businessowner's insurance contracts.

The term, benefit plan, does not include:

(1) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(2) Accident only coverage;

(3) Specified disease or specified accident coverage;

(4) Limited benefit health coverage;

(5) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a to-and-from-school basis;

(6) Medicare supplement policies;

(7) A state plan under the medical assistance program;

(8) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or

(9) Benefits provided in long-term care insurance policies for nonmedical services including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

Allowable charge. For a charge to be allowable it must be a Usual and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other participating only plans: This Plan will not consider any charges in excess of what an HMO or Participating Provider has agreed to accept as payment in full. Also, when an HMO or Participating Plan is primary and the Covered Person does not use an HMO or Participating Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or Participating Plan had the Covered Person used the services of an HMO or Participating Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, primary responsibility for health care services will be determined in the following order: Workers' Compensation, No-Fault Automobile, Medical Payments.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are married or are living together, whether or not they have ever been married:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated or are not living together, whether or not they have ever been married, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than fifty percent (50%) of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Plan Benefit Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claim Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

SECTION XII
THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges as a result of Injuries which were caused by the act or omission of a Third Party or for which a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan shall be entitled to claim an equitable lien on the proceeds of any amount Recovered by the Covered Person whether or not designated as payment for medical or dental expenses. The Covered Person further directs his/her attorneys or any other person or entity holding proceeds on the behalf of the Covered Person, whether obtained through settlement or judgment, to pay over such proceeds to the Plan. The equitable lien granted to the Plan shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) agrees to grant an equitable lien to the Plan on the proceeds of any amount recovered; and

(2) agrees that by acceptance of the medical or dental benefit he/she assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer; and

(4) agrees to direct his/her attorney or any other person or entity holding proceeds on his/her behalf to pay over such proceeds to the Plan.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person in relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver to the Plan Administrator all required instruments and documents as well as taking whatever steps are necessary to secure the Plan's right of Subrogation as a condition to having the Plan make benefit payments. In addition, the Covered Person or his/her agents will do nothing to prejudice the right of the Plan to Subrogate and will cooperate with the Plan in protecting its subrogation rights.

Conditions Precedent to Medical or Dental Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator Terms and Conditions. The Plan Administrator has a right to request periodic reports on and approve of all settlements and require the members assistance in protecting the Plan's subrogation rights which in effect the right of recovery by the plan for the payment of medical or dental benefits.

SECTION XIII
COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most Employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to Employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These Employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The Employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended.

Any Employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan

coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within

twelve (12) months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is sixty (60) days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within sixty (60) days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) twenty-nine (29) months after the date of the Qualifying Event, or (ii) the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends eighteen (18) months after the Qualifying Event if there is not a disability extension and twenty-nine (29) months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) thirty-six (36) months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is thirty-six (36) months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an eighteen (18)-month or twenty-nine (29)-month maximum coverage period is followed, within that eighteen (18)- or twenty-nine (29)-month period, by a second Qualifying Event that gives rise to a thirty-six (36)-months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18)-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed one hundred two percent (102%) of the applicable premium except the Plan may require the payment of an amount that does not exceed one hundred fifty percent (150%) of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is thirty (30) days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is thirty (30) days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or ten percent (10%) of the required amount.

Special COBRA premium assistance opportunity
The Federal Government through the passage of the "American Recovery and Reinvestment Act of 2009" has made a special COBRA opportunity available for certain Assistance Eligible Individuals.

Reduced COBRA premium
For a period not to exceed nine months, an Assistance Eligible Individual is treated as having paid any premium required for COBRA continuation coverage under the Plan if the individual pays thirty-five percent (35%) of the premium. Thus, if the Assistance Eligible Individual pays thirty-five percent (35%) of the premium, the Plan will treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for sixty-five percent (65%) of the premium.

Termination of eligibility for premium assistance
The Assistance Eligible Individual's eligibility for the subsidy terminates with the first month beginning on or after the earlier of:

- The date which is nine months after the first day of the first month for which the subsidy applies;

- The end of the maximum required period of continuation coverage for the qualified beneficiary under the Code's COBRA rules or the relevant State or Federal law (or regulation); or

- The date that the Assistance Eligible Individual becomes eligible for Medicare benefits under Title XVIII of the Social Security Act or health coverage under another group health plan (including, for example, a group health plan maintained by the new employer of the individual or a plan maintained by the employer of the individual's spouse).

However, eligibility for coverage under another group health plan does not terminate eligibility for the subsidy if the other group health plan provides only dental, vision, counseling, or referral services (or a combination of the foregoing), is a health flexible spending account or health reimbursement arrangement, or is coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

If a Qualified Beneficiary paying a reduced premium for COBRA continuation coverage under this provision becomes eligible for coverage under another group health plan or Medicare, then the Qualified Beneficiary is required to notify the Plan in writing. This notification must be provided to the Plan in the time and manner as is specified by the Secretary of Labor. If an Assistance Eligible Individual fails to provide this notification at the required time and in the required manner, and as a result the individual's COBRA continuation coverage continues to be subsidized after the termination of the individual's eligibility for such subsidy, a penalty will be imposed by the Department of Labor that is equal to one hundred ten percent (110%) of the subsidy provided after termination of eligibility.

Second COBRA election opportunity

The provision provides a special sixty (60) day election period for a Qualified Beneficiary who is eligible for a reduced premium and who has not elected COBRA continuation coverage as of the date of enactment. The sixty (60) day election period begins on the date the notice is provided to the Qualified Beneficiary of the special election period. However, this special election period does not extend the period of COBRA continuation coverage beyond the original maximum required period and any COBRA continuation coverage elected pursuant to this special election period begins on the date of enactment and does not include any period prior to that date. Thus, for example, if a covered Employee involuntarily terminated employment of September 10, 2008, but did not elect COBRA continuation coverage and was not eligible for coverage under another group health plan, the Employee would have sixty (60) days after date of notification of this new election right to elect the coverage and receive the subsidy. If the Employee made the election, the coverage would begin on the first period of coverage beginning after the date of the enactment date of the law, and does not include any period prior to that date. However, the coverage would not be required to last for eighteen (18) months. Instead the maximum required COBRA continuation coverage period would end no later than eighteen (18) months after September 10, 2008.

SECTION XIV
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Watertown School District #14-4 Employee Benefit Trust is the benefit plan of Watertown School District #14-4, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Watertown School District #14-4 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Watertown School District #14-4 shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or Dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable

Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for twelve (12) months after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefit Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

SECTION XV
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator.

PLAN NAME

Watertown School District #14-4 Employee Benefit Trust

PLAN NUMBER: 505

TAX ID NUMBER: 46-6001273

PLAN EFFECTIVE DATE: October 1, 1989

PLAN BENEFIT YEAR: January 1 – December 31

PLAN YEAR ENDS: October 1 – September 30

EMPLOYER INFORMATION

Watertown School District #14-4
PO Box 730
Watertown, South Dakota 57201-0730
(605) 882-6314

PLAN ADMINISTRATOR

Watertown School District #14-4
PO Box 730
Watertown, South Dakota 57201-0730
(605) 882-6314

NAMED FIDUCIARY

Watertown School District #14-4
PO Box 730
Watertown, South Dakota 57201-0730

AGENT FOR SERVICE OF LEGAL PROCESS

Watertown School District #14-4
PO Box 730
Watertown, South Dakota 57201-0730

CLAIMS ADMINISTRATOR

DAKOTACARE Administrative Services, Inc.
1323 South Minnesota Avenue
Sioux Falls, South Dakota 57105
1-800-325-5598

BY THIS AGREEMENT, Watertown School District #14-4 is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Watertown School District #14-4 on or as of the day and year first below written.

By _____
Watertown School District #14-4

Date _____

Witness _____

Date _____