EMPLOYEE WELFARE BENEFIT PLAN
WRAP-AROUND SUMMARY PLAN DESCRIPTION

OF

ST. CROIX CHIPPEWA INDIANS OF WISCONSIN

EFFECTIVE DATE: MAY 1, 2010
RESTATED DATE: MAY 1, 2022

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INTRODUCTION AND OVERVIEW OF THE PLAN

The intent of this Plan Document (the "Plan") is to assure that the written plan document complies with the requirements of the Employee Income Security Act of 1974 (also known as ERISA), as amended and the Internal Revenue Code for the Plan and each welfare benefit included in this Plan. St. Croix Chippewa Indians of Wisconsin (the "Employer") maintains this St. Croix Chippewa Indians of Wisconsin Health & Welfare Plan ("Plan").

The Plan provides a variety of welfare benefits through various programs (referred to as "Component Benefit Plans"). The Component Benefit Plans are listed in Schedule A. It is intended that this Plan Document provide an administrative framework for all of the Benefits that are provided under the Plan.

This document serves as both the formal plan document and summary plan description as required by ERISA. However, the provisions of the Component Benefit Plans (which may be set forth in an insurance policy, certificate of coverage, employee booklet, other summary plan descriptions and related benefit summaries or schedules, and enrollment materials) are incorporated herein by reference. Accordingly, both this document and all of the Component Benefit Plan documents collectively constitute the Plan.

For further information about the benefits provided under the Component Benefit Plans, refer to the specific documents issued by the insurer or administrator for each plan, as outlined in Schedule A, or contact the Plan Administrator.

Except as otherwise indicated by context, masculine terminology used in the Plan also includes the feminine, and terms used in the singular may also include the plural.

A. Participation in the Plan

Employees shall be considered eligible to participate in this Plan upon meeting the eligibility requirements of any one of the Benefit programs as listed in Schedule A. Eligibility to participate in each Benefit program is outlined in Schedule B.

B. Affiliates, Divisions, Subsidiaries

The Plan Sponsor has the right to include any affiliate, division or subsidiary under common control pursuant to Internal Revenue Code Section 414 in the Plan, and in any Component Benefit Plan (subject to the approval by any insurers and qualification under their underwriting guidelines).

STATEMENT OF RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles Plan participants to the following rights and protections:

A. Right to Examine Plan Documents

Plan participants have the right to examine all documents governing the Plan, including insurance policies, collective bargaining agreements, and any latest annual reports (Form 5500) filed by the Plan with the United States Department of Labor. The latest annual report can be found at www.efast.dol.gov. The Plan Administrator will tell the Plan participant where the other Plan documents are available for examination. Plan participants may examine any documents without charge.

B. Right to Obtain Copies of Plan Documents

Plan participants have the right to obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, including insurance policies, collective bargaining agreements, Plan documents and any annual reports (Form 5500) and an updated summary plan description (if any). The latest annual report can be found at www.efast.dol.gov. The Plan Administrator may request a reasonable charge for the copies.

C. Right to Continue Group Health Plan Coverage – Group Health Plans Only

Plan participants have the right to continue health care coverage for the participant and the participant's dependents if there is a loss of coverage under a group health plan (e.g., a medical, dental, or vision plan) as a result of a qualifying event. The participant or the participant's dependents may have to pay for such coverage. Participants should review the rules governing COBRA continuation rights in the group health plan Component Benefit Plan Documents.

D. Right to Written Explanation of Denial

If a Plan participant's claim for benefits under the Plan is denied or ignored, in whole or in part, a Plan participant has a right to obtain a written explanation of the reason for denial, and to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules (which are set forth in the Component Plan Document).

E. Fiduciaries

In addition to creating rights of Plan participants, ERISA imposes special obligations and duties upon the people (referred to as fiduciaries) who are responsible for the operation of the Plan. The fiduciaries of the Plan have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries. The fiduciaries also have a duty to protect any Plan assets for the benefit of Plan participants. No one, including the Employer, a union, or any other person, may fire a Plan participant or otherwise discriminate against a participant in any way to prevent a participant from receiving a Plan benefit or from exercising his or her individual rights under ERISA.

F. Enforce ERISA Rights

Under ERISA, there are steps participants can take to enforce the above rights. For example, if a participant requests a copy of Plan documents from the Plan and does not receive them within 30 days, the participant may file suit in Federal court. In such a situation, the court may require the Plan Administrator to give the participant the Plan documents requested and pay up to $149 a day until the participant receives the requested materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. ERISA gives Plan participants the right to file suit in a state or Federal court if a claim for benefits under the Plan is denied or ignored, in whole or in part. In addition, if a participant disagrees with the Plan's decision (or lack thereof) concerning the qualified status of a medical child support order, the participant may file suit in Federal court.

If it should happen that the Plan fiduciaries have misused the Plan's money, or that a participant has been discriminated against for asserting the participant's rights, then the participant can ask for help from the U.S. Department of Labor or file suit in a Federal court.

If a participant files a suit, the court will decide who must pay court costs and legal fees. If a participant is successful, the court may order the person the participant sued to pay those fees. If a participant loses (if, for example, the court finds the claim is frivolous), the court may order the participant to pay those costs and fees.

G. Assistance with Any Questions

If there are any questions about the Plan, participants should contact the Plan Administrator. If there are any questions about this statement or about participant rights under ERISA, or if assistance is

needed in obtaining documents from the Plan Administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

TERMINATION/MODIFICATION/AMENDMENT TO THE PLAN

The Plan Administrator has the discretionary authority to amend, modify or terminate the Plan or any portion of the Plan at any time, subject to applicable laws (and the terms of an applicable collective bargaining agreement, if any). The consent of Plan participants is not required to terminate, modify, amend or change the Plan. Any such amendment or termination will not affect the benefits that accrued prior to the date of such action taken by the Plan Administrator. A relationship with a Contract/Claims Administrator may be changed or terminated at the Plan Administrator's discretion. For any fully-insured plan, the insurance carrier generally has the right to amend or terminate the insurance policy in accordance with its terms.

A Contract/Claims Administrator or Insurer may terminate coverage or other administrative services if the Plan Administrator fails to pay the required fees or premiums in a timely manner as prescribed by the applicable contract. An Insurer may also terminate the insurance policy applicable to a fully-insured Component Benefit Plan on any premium due date if the number of persons insured is less than the minimum number required, or if the Plan Administrator fails to meet any other criteria set by the insurer that must continue to be satisfied.

Affiliates, divisions and subsidiaries reserve the right to terminate participation in the Plan or any Component Benefit Plan. And unless specifically excluded, the action of the Plan Administrator in amending, modifying or terminating a benefit or an entire Component Benefit Plan shall apply to all affiliates, divisions or subsidiaries covered by the Plan or Component Benefit Plan.

PLAN INFORMATION

The Plan identified on the following pages is subject to regulation under ERISA. **All plans outlined within this document have the following ERISA specifications in common:**

The Name of the Plan:	St. Croix Chippewa Indians of Wisconsin Health & Welfare Plan (the "Plan")
Name and Address and Phone Number of Employer:	St. Croix Chippewa Indians of Wisconsin 24663 Angeline Ave. Webster, WI 54893 715-349-2195
The Employer Identification Number (EIN):	39-1210835
Plan Number:	501
Type of Plan:	Welfare Plan providing medical, prescription drug, dental, vision, disability, and life insurance.
Type of Administration:	Fully-insured and self-funded contract administration provided in accordance with plan documents, third party administrative agreements, and group insurance policies and certificates.
Name of Plan Administrator: Business Address: Business Phone Number:	St. Croix Chippewa Indians of Wisconsin 24663 Angeline Ave. Webster, WI 54893 715-349-2195
Designated Agent for Legal Process: Address at which Process may be Served:	St. Croix Chippewa Indians of Wisconsin 24663 Angeline Ave. Webster, WI 54893
Plan Changes or Termination:	The Employer may terminate, suspend, withdraw, amend or modify any portion of the Plan in whole or in part at any time, subject to the applicable provisions of the group benefit contracts, corporate minutes and/or bylaws, or other written instrument.
Plan Fiscal Year End:	04/30

Administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan. In the absence of clear and convincing evidence that the Plan Administrator (or delegate) acted arbitrarily or capriciously, any determination by the Plan Administrator (or an authorized delegate of the Plan Administrator) shall be final and binding.

Description of Types of Funding Arrangements

The Component Benefit Plans are either fully-insured, self-funded or partially self-funded. See Schedule A for more information.

A. Fully-insured plan

In a fully-insured plan, benefits are provided under a group insurance policy entered into between the Employer and the Insurer. Claims for benefits are sent to the insurance company. The insurance company, not the Employer, is responsible for paying claims and for the financial risk of paying claims under the applicable Component Benefit Plan. The insurance carrier is also the ERISA fiduciary, with discretionary authority to make decisions on the payment of benefits, including determining claims and appeals, and otherwise administering the terms of the insurance policy. The Plan Administrator is generally responsible for determining who is eligible to participate in a fully-insured plan. Insurance premiums for Plan participants as well as employee contributions (pre-tax and/or after-tax, as applicable) are paid out of the general assets of the Employer, as needed.

Unless superseded by applicable law, if the terms of this document conflict with the terms of the insurance policies applicable to a fully-insured benefit, then the terms of the insurance policy will control.

B. Self-funded plan/Partially Self-funded plan

In a self-funded plan or partially self-funded plan, the Employer hires the Contract/Claims Administrator to process claims under the Plan. The Contract/Claims Administrator does not serve as an Insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract/Claims Administrator. The Contract/Claims Administrator processes the claims, then requests and receives funds from the Employer to make payment on the claims to participants or health care providers. The Employer is ultimately responsible for providing benefits under the self-funded plan, not the Contract/Claims Administrator. If the Plan is partially self-funded, the insurance company and the Employer share responsibility for paying benefits.

There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) are also paid out of the general assets of the Employer, as needed.

C. Special Information Regarding a Section 125 Plan

The Employer has established a "cafeteria plan" under Internal Revenue Code Section 125, which allows eligible employees to pay their portion of the premiums or required contributions for medical, dental, and vision coverages on a pre-tax basis. By enrolling in one or more of these coverages, an employee authorizes the Employer to reduce the employee's wages by an amount equal to the applicable share of the premium for the coverage elected (on a pre-tax basis, when possible).

When an employee's share of the premium is paid on a pre-tax basis, the employee's salary reduction amount is not included in taxable income for purposes of federal and most state and local income taxes. Social Security tax is also not paid, which means contributions may reduce wages reported for Social Security purposes and could ultimately reduce an employee's Social Security benefit amount.

If the employee is paying for coverage on a pre-tax basis through the cafeteria plan, then salary reduction elections will be effective for the entire Plan Year and cannot be changed during the Plan Year, unless an allowable change event occurs, as defined in the Section 125 plan document. Examples of allowable change events include marriage, divorce, birth or adoption of a child, death of a spouse or child, loss of coverage under another employer's group health plan due to termination of employment, change in employment status resulting in gain or loss of eligibility for coverage, or changes in the cost or coverage.

Eligibility and Benefit Termination Specifications

A. Employee Eligibility and Participation

Certain employees and their dependents are eligible to participate in the Component Benefit Plans. Eligibility may vary by Component Benefit Plan. Schedule B contains the eligibility requirements of each Component Benefit Plan, including but not limited to:

a) any job classifications that are eligible to participate in the plan;
b) any service requirement, generally referred to as a waiting period, that must be satisfied prior to becoming eligible to participate.

Eligible employees will be provided enrollment materials which outline the enrollment procedures for each Component Benefit Plan. Online enrollment may be required for all or some of the benefits included in the Plan. Any eligible employee and/or eligible dependent who is properly enrolled in a Component Benefit Plan will be a "participant" in the Plan.

B. Dependents Eligibility

Eligible employees may enroll their spouse, children, and other dependents. Information regarding dependent eligibility requirements can be found in the Component Benefit Plan Documents.

In order to enroll eligible dependents in the Plan additional documentation may be required as part of the enrollment process. This may include but is not limited to:

- Providing marriage certificates for spouses and information about coverage that is available through a spouse's employment.
- Birth certificate/ certificates of adoption, and full time student documentation, where applicable, for dependent children.
- Physician's certification of disability for disabled dependents.

C. Benefit Termination

In general, a participant's coverage under the Plan or any particular Component Benefit Plan will terminate (subject to any available COBRA or state continuation rights) upon the earliest of the following:

- When the Employee terminates employment, retires or dies;
- When the Employee or other participant no longer meets the eligibility requirements for participation in the Plan or a particular Component Benefit Plan;
- When a participant fails to timely and/or completely pay the required share of premiums, if any, for the Plan or a particular Component Benefit Plan (including during a participant's paid or unpaid leave of absence); or
- When the participant fails to timely re-enroll in the Component Benefit Plan, if required; or
- When the Plan or a particular Component Benefit Plan is terminated by the Plan Sponsor or the insurer.

Additionally, more specific information regarding loss of benefits and when benefits terminate can be found in the Component Benefit Plan Documents.

The Plan Administrator may, in its sole discretion, cause a participant's coverage under the Plan or any particular Component Benefit Plan to terminate if such participant does any of the following: provides false information or makes material misrepresentations in connection with a claim for benefits; covers or enrolls an individual who is not eligible to participate in the Plan (e.g., adding a spouse before the date of marriage or continuing to cover the spouse after a divorce or adding or continuing to cover a child who does not meet the Plan's definition of Dependent); permits a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions. To the extent permitted by law, the Plan Administrator may seek reimbursement for all claims or expenses paid by the Plan as a result of the false representation or fraud, and may

reduce future benefits as an offset for amounts that should be reimbursed, or pursue legal action against such individual.

With respect to medical coverage under the Plan, any termination of coverage will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation, failure to pay or remit premium, coverage may be terminated retroactively (called a "rescission" of coverage) to the extent permitted by law, in which case the affected individual(s) shall be provided notice of the rescission and with an opportunity to appeal the rescission as required by law.

COMPLIANCE WITH STATE AND FEDERAL LAWS

To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (PPACA).

SPECIAL ENROLLMENT PERIODS

Special Enrollment Rights

If an Employee declines enrollment for himself or any dependents (including a spouse) because of other health insurance or group health plan coverage, the Employee may be able to enroll himself and his dependents in this plan if the Employee and his dependents lose eligibility for that other coverage (or if the employer stops contributing toward such other coverage). However, the Employee must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If the Employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, he may be able to enroll himself and any dependents provided that a request for enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption. If the Employee adds coverage under these circumstances, he may add coverage during the Plan year. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption. The plan does not permit additions of coverage during the Plan year except for newly eligible persons and special enrollees.

Special enrollment rights also may exist in the following circumstances: A special enrollment period under this Plan will apply If the Employee or dependent:

1. was covered under Medicaid or a state child health insurance program (SCHIP) and that coverage terminated due to loss of eligibility, or

2. becomes eligible for premium assistance under Medicaid or a state child health insurance program.

The Employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP coverage, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants when group health coverage would otherwise end. For more information about rights and obligations under the Plan and under federal law, review the Plan's Summary Plan Description or contact the Plan Administrator.

Other options may be available when group health coverage is lost

For example, a participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, a person may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of health Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." The Employee, his/her spouse, and any dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An Employee becomes a qualified beneficiary if he/she loses coverage under the Plan because of the following qualifying events:

- His/her hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct.

The spouse of an Employee becomes a qualified beneficiary if he/she loses coverage under the Plan because of any of the following qualifying events:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- A divorce or legal separation from the Employee.

In general, only individuals covered by a group health plan immediately prior to the qualifying event may elect COBRA. However, this rule will not apply in the following situations:

- If the Employee cancels a spouse's coverage in anticipation of a divorce, then, if the Plan Administrator receives timely notice of the divorce (as explained below) and determines that the Employee dropped spousal coverage in anticipation of the divorce, then COBRA continuation will be made available to the former spouse effective on (but not before) the date of the divorce.
- If the Employee was covered by a group health plan on the day before the first day of a Family and Medical Leave Act (FMLA) leave of absence, and a qualifying event occurs during or in connection with the FMLA leave of absence (e.g., the Employee does not return to work following the FMLA leave of absence and, therefore, experiences a termination of employment), then COBRA continuation coverage will be made available on the last day of the FMLA leave of absence even if the coverage was cancelled earlier in the FMLA leave period (e.g., for non-payment of premiums).

The Employee's dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Employee must notify the Plan Administrator within 60 days after the qualifying event occurs. The Employee must provide this notice to: **St. Croix Chippewa Indians of Wisconsin.**

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or a reduction of the Employee's hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If the Employee or anyone in the Employee's family who is covered under the Plan is determined by Social Security to be disabled, and the Employee notifies the Plan Administrator in a timely fashion, the Employee and his/her entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If the Employee's family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in the family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the Employee or former Employee dies or becomes entitled to Medicare benefits (under Part A, Part B, or both) or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only

available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for the Employee and the Employee's family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. To learn more about many of these options go to www.HealthCare.gov.

If there are any questions

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in the area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Plan informed of address changes

The Employee can protect his/her rights and the rights of his/her family by informing the Plan Administrator of any changes in the addresses of family members. The Employee should also keep a copy of any notices sent by the Plan Administrator for his/her records.

For more information on COBRA and your rights you may call or make a written request to:

St. Croix Chippewa Indians of Wisconsin
Benefits Department
24663 Angeline Ave. Webster, WI 54893
715-349-2195

Shorter maximum coverage period for health flexible spending accounts

The maximum COBRA coverage period for a health flexible spending arrangement (health "FSA") maintained by the Employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurs. In addition, if at the time of the qualifying event the Employee has withdrawn more from the FSA than the Employee has had credited to the FSA during the plan year, no COBRA right is available at all.

Other Rules and Requirements

Same Rights as Active Employees to Add New Dependents

A qualified beneficiary generally has the same rights as similarly situated active Employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, *"Children Born to or Placed for Adoption with the Covered Employee During COBRA Period,"* for information about how certain children acquired by a covered Employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if changes to COBRA coverage are needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date of a change*** *(adding or dropping dependents, for example).*

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period

A child born to, adopted by, or placed for adoption with a covered Employee or former Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee or former Employee is a qualified beneficiary, the Employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee a change to COBRA coverage is needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date such a change is desired.***

Alternate Recipients Under Qualified Medical Child Support Orders (QMCSO)

A child of the covered Employee or former Employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Employee's period of employment with the Employer is entitled the same rights under COBRA as an eligible child of the covered Employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if a change to COBRA coverage is needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date such a change is desired.***

PLANS NOT SUBJECT TO COBRA

Life insurance and disability benefits are not subject to COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion period may be exercised within a specific period of time following the date of termination pursuant to any applicable state law. If a Plan participant wishes to learn more about a conversion policy and whether one is available (or any portability option that may be available), Plan participants should refer to the respective Certificate of Coverage for specific requirements.

CLAIMS PROCEDURES

A. Filing of Claims

This Section shall apply for any claim for benefits under a Component Benefit Plan unless that plan has a claims procedure that is compliant with ERISA Section 503. If the Component Benefit Plan has a claims procedure that is compliant with ERISA Section 503, the claims procedure of the Component Benefit Plan shall apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the plan participant or an authorized representative of the plan participant in accordance with these claim filing procedures.

Claims must generally be filed in writing with the applicable Component Benefit Plan insurer or administrator. (However, if a claim is an urgent care claim, an oral filing is acceptable.) If a claim is filed and the information is incomplete so as to prevent the claim from being processed, the participant will be given notice and an opportunity to complete the claim and refile.

An inquiry is not considered as a claim filing when it relates to general provisions of a plan (such as eligibility for participation, whether a service will be considered for benefits and prior approval of that service is not a requirement), the inquiry must be directed to the Plan Administrator.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the participant's medical condition may act as an authorized representative with or without prior notice.

B. Timing of Notice of Claim

The Plan Administrator shall notify the plan participant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Component Benefit Plan under which the claim for benefits arises.

In General
Notice will be provided within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 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 plan participant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Group Health Plan Claims
The timeframe for benefit determinations under group health plans shall be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this section, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

Disability Plan Claims (or Claims Involving Disability)
Notice will be provided 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 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 plan participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the plan participant prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section shall explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the plan participant shall be afforded at least 45 days within which to provide the specified information.

C. Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Plan Administrator shall provide the Plan participant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Plan participant must take if he wishes to appeal the denial including a statement that the Plan participant may bring a civil action under ERISA.

In addition, if the wholly or partially denied claim is by a Component Benefit Plan providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that

such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Plan participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Component Benefit Plan providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section may be provided orally within the timeframe required provided that a written or electronic notification is furnished to the plan participant not later than 3 days after the oral notification.

In the case of a disability claim or a claim involving disability, any adverse benefit determination shall include a discussion of the decision, with the basis for disagreeing with the views or decisions of any treating health care professionals, vocational experts, or other payers of benefit who granted the claimant's similar claims (including disability determinations by the Social Security Administration (SSA)). Any adverse benefit determination shall also include the plan's specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such plan rules, guidelines, protocols, standards or other similar criteria do not exist. Any adverse benefit determination shall be provided in a culturally and linguistically appropriate manner.

The claimant 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 claim.

D. Appeal of Denied Claim

If a Plan participant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Plan participant shall lose the right to appeal if the appeal is not timely made.

(1) The Plan participant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Plan participant may desire to provide. The Plan Administrator shall consider the merits of the Plan participant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances, as the Plan Administrator may deem relevant.

(2) In addition to the requirements of paragraph (A) above, if the claim is under a Component Benefit Plan providing group health or disability benefits, the claims procedures shall be determined in accordance with paragraph (C) and 2560.503-1(h)(4).

The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Plan participant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Component Benefit Plan providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

In the case of a disability claim or a claim involving disability, a claimant may review the claim file and present evidence and testimony as part of the claims and appeals process. Further, the Plan

Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim. Such evidence shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date. Prior to issuing an adverse benefit determination on review based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale. Such rationale shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date.

In the event of any error, a claimant may request a written explanation from the plan, including a specific description of the plan's bases, if any, for asserting that the error is *de minimis* and should not result in the deemed exhaustion of administrative remedies. The Plan shall provide this written explanation, if requested, within 10 days.

E. Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator shall provide the Plan participant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Plan participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Plan participant's claim for benefits, and (4) a statement describing the Plan participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Component Benefit Plan providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

F. Exhaustion of Remedies

Before a suit can be filed in Federal court, claimants must exhaust internal remedies.

G. Additional Claims Processes

Applicability
This Subsection shall apply to the extent (1) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (2) the Plan is not a grandfathered health plan under the Affordable Care Act.

Effective Date
This Subsection shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Affordable Care Act.

Internal Claims Process
The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

Adverse Benefit Determination
An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

Expedited Urgent Care Determination
The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Plan participants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

Full and Fair Review
A Plan participant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Plan participants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Plan participant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

Notice
A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Deemed Exhaustion of Internal Claims Process
If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the plan participant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

H. External Claims Process

State Process
To the extent the Plan is required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer must comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

Federal Process
To the extent the Plan is not required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

I. Minor or Legally Incompetent Payee

Benefits may become payable under a Component Benefit Plan to a Plan participant's estate, or to a minor or person who is not capable of executing a valid release. The Plan may in such an event make payment to one of the following:

1. A person who has assumed the care and support of such person, or is a designated beneficiary;
2. A personal representative of the Plan participant's estate; or
3. Any person related to the Plan participant by blood or marriage.

Such payment shall fully discharge the Plan Administrator and the Plan from further liability.

J. Missing Payee

After reasonable efforts have been made to identify and/or locate a Plan participant or beneficiary, if the Plan Administrator is unable to make a payment that is due, such payment and all subsequent payments otherwise due shall be forfeited one year after the date any such payment first became due.

ACA COMPLIANCE

The Plan complies with the requirements of the Affordable Care Act (ACA), including but not limited to the coverage of preventive services without cost sharing, Women's Care services, Coverage for Clinical Trials, and Emergency Room Access. The Health Plan provided under this document is affordable based on ACA guidelines; therefore, employees are not eligible to obtain a Federal subsidy.

A. ACA Employer Shared Responsibility Compliance

The Plan complies with the ACA Shared Responsibility requirements to offer medical coverage to full time employees and their dependents. To accomplish this, the Plan has adopted the IRS Look Back Safe Harbor to measure and verify hours of service for variable hour employees. Employees who are determined to meet the ACA definition of full time during the Look Back Period (as designated by the Plan Administrator) will be deemed to be eligible for the subsequent Stability Period (as designated by the Plan Administrator) and shall be offered coverage accordingly.

B. ACA Eligibility and Enrollment

These policies and procedures supplement certain terms of eligibility set forth in the Employer's medical plan document. These policies and procedures (the "Procedures") are hereby incorporated into and made part of the Employer's group medical plan (the "Plan"). These Procedures along with the Plan Document constitute the complete Plan Document.

Definitions

Break in Service means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the period of employment (determined after application of the procedures applicable to Special Unpaid Leaves of Absence prescribed herein.)

Calendar Month means one of the 12 months named in the calendar (e.g. January, February, etc.).

Employee means an individual classified by the Employer as a common law employee of the Employer, determined in accordance with rules and regulations issued by the Internal Revenue Service. Such term shall not include individuals classified by the Employer as independent contractors (including any person who later becomes reclassified as an employee by the Internal Revenue Service or a court of competent jurisdiction). For purposes of this subsection, any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Initial Measurement Period means the 12 Calendar Month period beginning on the first day of the Calendar Month coinciding with or next following the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to an Employee on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Measurement Period means the Initial Measurement Period or the Standard Measurement Period, as applicable.

Month means a period that begins on any date following the first day of a calendar month and that ends on the immediately preceding date in the immediately following calendar month (for example, from February 2 to March 1 or December 15 to January 14).

New Employee Stability Period means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

Ongoing Employee shall have the same meaning as Ongoing Employee set forth in the Plan Document.

Ongoing Employee Stability Period means the 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan's Standard Measurement Period.

Qualifying Part-time Employee shall have the same meaning as Qualified Part-time Employee set forth in the Plan Document.

Regular Full-Time Employee means a common law employee who is regularly scheduled to work 30 Hours of Service or more per Week.

Seasonal Employee means an Employee hired by the Employer into a position that is typically no longer in duration then six (6) months and begins at the same time of the year each year.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (a) Leave protected by the Family and Medical Leave Act; (b) leave protected by the Uniformed Services Employment and Reemployment Rights Act; or (c) Jury Duty (as reasonably defined by the Employer),

Standard Measurement Period means the 12-month period that begins each March 1 and ends February 28. The Employer may make adjustments to the Standard Measurement Period with respect to an Employee on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Week means any seven (7) consecutive calendar-day period.

C. Additional Terms of Eligibility for Qualifying Part-time Employees and Ongoing Employees

The Plan Administrator will determine a Qualifying Part-Time Employee's and an Ongoing Employee's eligibility for coverage under the Plan in accordance with the following requirements:

a. An Employee's Hours of Service during the applicable Measurement Period will be considered in determining eligibility for coverage under the Plan to the extent not preceded by a Break in Service.

b. Impact of Payroll Periods: For payroll periods that are one week, two weeks, or semi-monthly in duration, the Employer is permitted to treat as a Measurement Period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the Measurement Period, provided that the Measurement Period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the Measurement Period. The Employer may also treat as a Measurement Period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the Measurement Period, provided that the Measurement Period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the Measurement Period.

c. If the Employee experiences a Break in Service during a Measurement Period and then again resumes Hours of Service following a Break in Service, such Employee will be treated as a new Employee upon the date that the Employee resumes Hours of Service for the Employer.

d. Impact of Special Unpaid Leaves of Absence: If the Employee takes a Special Unpaid Leave of Absence during a Measurement Period, the Employer will disregard all consecutive Weeks of such unpaid leave when determining the average Hours of Service during the applicable Measurement Period.

e. Each Employee's Hours of Service will be determined in a manner consistent with Internal Revenue Code Section 4980H and the regulations issued thereunder.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Privacy Rules and Security Rules under HIPAA apply to certain benefits of the Plan that constitute "covered entities" within the meaning of HIPAA (e.g. health plans). This Section applies to self-funded health benefits (i. e., medical, dental, healthcare reimbursement accounts) as noted in Exhibit A.

A. Use and Disclosure of Protected Health Information (PHI)

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

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

(1) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
(2) coordination of benefits;
(3) processing of health benefits claims (including appeals and other payment disputes);
(4) subrogation of health benefit claims;
(5) employee contribution determinations;
(6) adjusting amounts due based on overall health status and demographic characteristics of the participants enrolled;
(7) billing, collection activities, and related health care data processing;
(8) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
(9) obtaining payment under a contract for reinsurance (including stop-loss and excess risk insurance);
(10) medical necessity reviews or reviews of appropriateness of care or justification of charges;
(11) utilization review, including pre-certification, preauthorization, concurrent and retrospective review;
(12) disclosure to consumer reporting agencies related to the collection of premiums or reimbursements; and
(13) reimbursement to the Plan.

Health care operations include, but are not limited to, the following activities:

(1) quality assessment;
(2) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting

health care providers and patients with information about treatment alternatives and related functions;

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

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

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

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

(7) business management and general administration activities of the Plan, including, but not limited to:
   (i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; and
   (ii) customer service, including data analyses for policyholders;

(8) resolution of internal grievances; and

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

B. Employer's Obligations under the Privacy Rules

Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. Notwithstanding the foregoing, this provision shall be applicable only to self-funded Benefits. It is the Employer's intent to remain "hands-off" with respect to PHI related to insured Benefits. The Employer agrees to:

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

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

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

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

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

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

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

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

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

(j) if feasible, return or destroy all PHI received by the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which

disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

C. Employer's Obligations under Security Rules

If the Employer creates, receives, maintains, or transmits electronic PHI, also referred to as ePHI, other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions, the Employer will:

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

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

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

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

D. Separation Between the Plan and the Employer

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

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

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

E. Limitation of PHI Access and Disclosure

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

F. Noncompliance Issues

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

G. Amendments and Guidance

To the extent HIPAA is amended and/or enforcement agency guidance is issued after the Effective Date, the Plan shall be administered in accordance with the law, including such amendments and/or changes.

REIMBURSEMENT/SUBROGATION

A. Self-funded Component Benefit Plan Provisions

Right of Reimbursement/Subrogation

If a participant is injured or becomes ill due to the actions of any third party and becomes entitled to receive any benefit covered under a Component Benefit Plan, the participant must assist the Component Benefit Plan in recovering from the responsible third party (or its insurer). By filing a claim for payment of benefits under a Component Benefit Plan or by receiving benefit payments from a Component Benefit Plan for an injury or illness for which a third party may be responsible, the participant gives the rights that the participant has to recover from the third party (or insurer) to the Component Benefit Plan and the Employer, to the extent of the benefits paid by (or owed to the participant) by that Component Benefit Plan. The Plan Administrator or the Employer has the right to sue, compromise or settle with any responsible third party (or its insurer) on behalf of the participant.

The Component Benefit Plan can recover from a third party or any liability insurer or other insurer covering the third party, including the participant's own uninsured/underinsured motorist coverage and any medical or no fault benefits that are paid or payable, to the extent that the third party may be liable. For purposes of this Reimbursement/Subrogation section, the term "participant" shall include their dependents and, if applicable, beneficiaries.

Rights of Component Benefit Plans

Where a third party may be responsible for a participant's injury or illness, the Component Benefit Plans reserves the right to either:

- Pay all or part of the benefits covered under the Component Benefit Plans and be reimbursed from a settlement or judgment against the responsible third party; or
- Delay payment of all or part of the benefits covered under the Component Benefit Plans and require the third party to pay the benefits as part of a settlement or judgment.

Participant Cooperation

Participants must cooperate with the Plan Administrator and the Employer to exercise their right of reimbursement/subrogation and to help them recover benefits. Each participant may be required to sign a reimbursement/subrogation agreement prior to payment of any benefits. However, if the Component Benefit Plan pays any benefits prior to obtaining a signed reimbursement/subrogation agreement, such payment will not operate as a waiver of the reimbursement/subrogation right or of the right to require the participant to sign a reimbursement/subrogation agreement prior to receipt of any further benefit payments. The reimbursement/subrogation agreement is binding on the participant regardless of whether:

- The payment received from the third party (or its insurer) is the result of a legal judgment, arbitration award, compromise settlement or any other arrangement,
- The third party has admitted liability for the payment, or
- Medical expenses are itemized in the third party (or its insurer) payment.

Participant Notification Requirement

Participants are required to notify the Plan Administrator, in writing, of any injury or illness that provides or may provide the Component Benefit Plan subrogation and/or reimbursement rights under this provision. This notice must be provided to the Plan Administrator as soon as reasonably possible after occurrence of the injury or illness. The Plan Administrator may, in its sole discretion, at that time or any other time:

- Instruct the participant to seek, not to seek, or to discontinue seeking payment or reimbursement on behalf of the Plans; and
- Pursue such payment or reimbursement independently in the same or a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether.

Reimbursement of Component Benefit Plans

If a participant makes or files a claim, demand, lawsuit or other proceeding against a third party who may be liable, the participant must seek payment or reimbursement on behalf of the Component Benefit Plans for the amount of benefits covered by the Component Benefit Plans (whether or not paid). The participant must notify the Plan Administrator prior to making or filing any such claim, demand, lawsuit or other proceeding. Any compromise or settlement entered into by a participant which attempts to reduce or limit the amount of the payment for medical or any other expenses covered by the Component Benefit Plans (whether or not paid) to an amount that is less than the benefits covered by the Component Benefit Plan (whether or not paid) shall not be effective unless the Plan Administrator consents to the compromise or settlement in writing. If the participant receives a recovery, failure to reimburse the Component Benefit Plans according to the reimbursement/subrogation agreement may result in civil action against the participant and/or their attorney.

The Plan shall be considered to have an equitable lien against monies received by the participant (or any individual, trust or other person or entity acting on behalf of the participant) and shall be

reimbursed first and fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by such individual. Pending reimbursement, the participant (or such individual's representative who receives any such recovery) shall be deemed to hold such amounts in constructive trust for the benefit of the Plan. The Component Benefit Plans have the right to be reimbursed in full before any amounts (including attorney's fees incurred by the participant) are deducted from the proceeds, judgment, settlement, or award, even if the participant is not "made whole". If a participant receives a settlement, judgment or recovery which does not cover all of the participant's damages (including Plan benefits), the Plan Administrator may on behalf of the Component Benefit Plans accept less than the full amount of Plan benefits, such as a percentage of the amount recovered; however, this is within the Plan Administrator's discretion.

Fully-insured Component Benefit Plan Provisions

Component Benefit Plan Document(s) will set forth the insurance carrier's rights to reimbursement or to subrogate a recovery for that plan.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- made in error; or
- made after the date the person should have been terminated under this Plan; or
- made to any participant or any party on behalf of a participant where the Plan Sponsor determines the payment to the participant or any other party is greater than the amount payable under this Plan.

The Plan has the right to recover from participants if the Plan has paid them or any other party on their behalf.

NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal, state or local income tax purposes, or that any other federal, state or local tax treatment will apply to or be available to any participant. It shall be the obligation of each participant to determine whether each payment under the Plan is excludable from the participant's gross income for federal, state and local income tax purposes, and to notify the Employer if the participant has reason to believe that any such payment is not so excludable.

NO ASSIGNMENT OF RIGHTS OR BENEFITS

Except to the extent specifically provided under the terms of a Component Benefit Plan, the rights of a participant under the Plan (including but not limited to the rights to appeal a benefit determination or payment, to bring a suit for benefits, or other remedies under ERISA) may not be sold, transferred, assigned, or pledged to any other person or entity. In addition, the benefits payable under the Plan shall not be subject to sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, and charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer shall not in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

SEVERABILITY

If any provision of the Plan is determined to be invalid or unenforceable, it shall not have an effect on the remainder of the Plan. The Plan shall be construed and enforced as if such provision had not been included.

APPLICABLE LAW

Any provision of the Plan that is in conflict with federal law or an applicable state law that requires precedence, shall be amended to conform to the minimum requirements of those laws.

NOT AN EMPLOYMENT CONTRACT

None of the Plans or benefits discussed on the preceding pages are to be considered contracts for employment between the Employee and the Employer. The Plans do not guarantee the Employee the right of continued employment nor do they limit the Employer's right to discharge the Employee.

INDEMNIFICATION

The Employer shall indemnify and hold harmless any person serving as the Plan Administrator from any and all losses, claims, damages, expense (including court costs and attorneys' fees) incurred in connection with the duties and responsibility delegated to them under the Plan to the extent not covered by insurance, unless due to the person's own gross negligence, willful and intentional misconduct or lack of good faith.

ADOPTION PAGE

St. Croix Chippewa Indians of Wisconsin previously established a program of benefits representing an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, called the St. Croix Chippewa Indians of Wisconsin Health & Welfare Plan (the "Plan") Plan number 501, effective May 1, 2022. By signing below, St. Croix Chippewa Indians of Wisconsin adopts this Restated Summary Plan Description.

St. Croix Chippewa Indians of Wisconsin

By: Kelley Bertuleit
Authorized Representative

Date: 10 / 12 / 2022

Witnessed:

By: ______________________

Date: 10 / 12 / 2022

SCHEDULE A

PLAN BENEFITS

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claims Administrators. These services include administering claims and providing customer service.

Type of Plan	Policy No. or Group No.	Type of Funding	Contribution
• **Medical Plan (PPO/HDHP)** *AmeriHealth* 1900 Market St. Suite 500 Philadelphia, PA 19103 1-651-662-4593	50748	Self-funded	Employer and Employee Contributions
• **Dental** *Humana Dental* 1100 Employers Blvd. Green Bay, WI 54344	WI3E1495/WI3E1486	Fully Insured	Employer and Employee Contributions
• **Vision** *Humana Vision* 1100 Employers Blvd. Green Bay, WI 54344	WI6V0105	Fully Insured	Employer and Employee Contributions
• **Basic Life Insurance/AD&D** *Principal* P.O. Box 9394 Des Moines, IA 50306-9394 (800) 547-7754	1094778	Fully-insured	Employer Contributions
• **Voluntary Life Insurance** *Principal* P.O. Box 9394 Des Moines, IA 50306-9394 (800) 547-7754	1094779	Fully-insured	Employee Contributions
• **Short-term Disability** *Formula Benefits* 2919 Eagandale Blvd., Suite 120 Eagan MN 55121 888-686-0513	N/A	Self-Funded	Employee Contributions
• **Long-term Disability** *Principal* P.O. Box 9394 Des Moines, IA 50306-9394 (800) 547-7754	1094779	Fully-insured	Employee Contributions
• **Section 125 Plan (Health Care and Dependent Care FSA)** *SelectAccount* 1750 Yankee Doodle Road Eagan, MN 55121 651-662-2320	N/A	Self-funded	Employee Contributions

SCHEDULE B

ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility for coverage under the Plan may vary by the type of benefit. Unless otherwise listed below, employees will be eligible based on satisfaction of the following requirements.

Affiliates, Divisions, Subsidiaries Included	Effective Date	Termination Date

Eligible Employees	Work Hour Requirement	Line of Coverage	Waiting Period
Full-time employees	30 hours per week	Medical, Dental, Vision, Life, Short Term Disability and Long Term Disability	The first of the month following 60 days.

Reinstatement of Benefits Following (Medical Leave of Absence or Layoff):

Employees who are laid off and then recalled within 90 days shall be eligible for the exact same benefits that were in place at point of layoff.

SCHEDULE C

HEALTH LAW NOTICES

Michelle's Law Notice

If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave

Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only

If an Employee or the Employee's child(ren) are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from State Medicaid or CHIP programs. If the Employee or his/her child(ren) aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs but may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If the Employee or his/her dependents are already enrolled in Medicaid or CHIP and live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If the Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they might be eligible for either of these programs, they can contact their State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If the Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer's plan, the employer must allow the Employee to enroll in the employer plan if not already enrolled. This is called a "special enrollment" opportunity, and the Employee must request coverage within 60 days of being determined eligible for premium assistance. If the Employee has questions about enrolling in their employer's plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid	KANSAS – Medicaid
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Disclosures

Women's Health and Cancer Rights Act of 1998

The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

a. Reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphademas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage 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 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.86% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. *

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

HIPAA Notice of Privacy Practices

The St. Croix Chippewa Indians of Wisconsin Group Medical Plan (the "Plan"), which includes medical, dental, vision, and flexible spending account coverages offered under the St. Croix Chippewa Indians of Wisconsin Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of your personally identifiable health information. This Notice is being provided to inform you of the policies and procedures St. Croix Chippewa Indians of Wisconsin has implemented and your rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of your health information.

Use and Disclosure of Your Health Information by the Plan that Do Not Require Your Authorization: The plan may use or disclose your health information (that is protected health information (PHI), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits. Your health information may also be used or disclosed in order for the Plan to carry out its own operations regarding the administration of the Plan and provide coverage and services to the Plan's participants. For example, the Plan may use your health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to your health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to you to allow you to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If you are an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to you on health-related benefits and services that may be of interest to you.

Notice in Case of Breach
St. Croix Chippewa Indians of Wisconsin is required maintain the privacy of your PHI; provide you with this notice of its legal duties and privacy practices with respect to PHI; and to notify you of any breach of your PHI.

Use and Disclosure of Your Health Information by the Plan that Does Require Your Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Your Rights with Respect to Your Health Information: You have the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: You may request the Plan to restrict uses and disclosures of your health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by you out of your own pocket. If you wish to request a restriction, please send it in writing to HIPAA Privacy Officer, at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195.

Right to Inspect and Copy Your Health Information: You may inspect and obtain a copy of your health information the Plan maintains. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195. Your request may be denied in whole or part and, if so, the Plan will provide you with a written explanation of the denial.

Right to an Accounting of Disclosures: You may request a list of disclosures made by the Plan of your health information during the six years prior to your request (or for a specified shorter period of time), however, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which you provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting your HIPAA Privacy Officer at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195. The accounting will be provided within 60 days from your submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: You may request that the Plan communicate with you about your health information in a certain way or at a certain location if you feel the disclosure could endanger you. You must provide the request in writing to your HIPAA Privacy Officer at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: You may request a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. Please contact your HIPAA Privacy Officer at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of your health information as related in this Notice and to provide this Notice to you of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If you wish to exercise your rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, please contact the HIPAA Contact Person, at St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Ave. Webster, WI 54893 715-349-2195. You may also file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated.

Important Notice from St. Croix Chippewa Indians of Wisconsin About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Croix Chippewa Indians of Wisconsin and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Croix Chippewa Indians of Wisconsin has determined that the prescription drug coverage offered by the St. Croix Chippewa Indians of Wisconsin Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current St. Croix Chippewa Indians of Wisconsin coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current St. Croix Chippewa Indians of Wisconsin coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with St. Croix Chippewa Indians of Wisconsin and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St. Croix Chippewa Indians of Wisconsin changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/14/2022
Name of Entity/Sender:	St. Croix Chippewa Indians of Wisconsin
Contact Position:	Benefits Director
Address:	24663 Angeline Ave. Webster, WI 54893
Phone Number:	715-349-2195

APPLIES TO HIGH DEDUCTIBLE HEALTH PLAN ONLY

Important Notice From St. Croix Chippewa Indians of Wisconsin About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Croix Chippewa Indians of Wisconsin and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Croix Chippewa Indians of Wisconsin High Deductible Health Plan has determined that the prescription drug coverage offered by St. Croix Chippewa Indians of Wisconsin is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the St. Croix Chippewa Indians of Wisconsin high deductible health plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from St. Croix Chippewa Indians of Wisconsin. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with St. Croix Chippewa Indians of Wisconsin, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the St. Croix Chippewa Indians of Wisconsin high deductible health plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the St. Croix Chippewa Indians of Wisconsin high deductible health plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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