Central Minnesota Community Corrections

Serving Aitkin, Crow Wing and Morrison Counties

Administration Office
322 Laurel Street, Suite 32 • Brainerd, MN 56401
218.824.1294 • FAX 218.824.1295

TO: Jerry Negen
Paul M. Thiede
Sharon Richardson
Stephenie Och
Duane Johnson
Cheryl Meld
Kameron Genz
Brian Middendorf
Nancy Johnson-Houg
Laurie Westerlund

FROM: CMCC Management Team

DATE: October 12, 2015

RE: **ADVISORY BOARD MEETING NOTICE**

The Advisory Board Meeting scheduled for **Thursday, November 5, 2015 at 10:30 a.m.**. We will be meeting at the **Crow Wing County Land Services Building, Meeting Room #1, 322 Laurel Street, Brainerd, MN 56401.**

Attached please find an agenda for the upcoming meeting and minutes from the April 16, 2015 meeting.

Please contact Elizabeth DeRuyck at 218-927-7281 or ederuyck@cmncc.org if you are unable to attend this meeting. Thank you.

cc: Victor Moen
Therese Norwood
Nicole Norgard
Sue Bingham

Handout 3A


Clean, Drain, Dry for Aquatic Invasive Species
AITKIN COUNTY WATERCRAFT INSPECTOR
MINNESOTA WATERCRAFT INSPECTOR

Aitkin County Aquatic Invasive Species (AIS) 2015 Summary

October 27, 2015

*September 2014 Aitkin County received $125,061

*July 2015 received an additional $138,964

*December 2015 will receive another $138,950

*Aitkin County SWCD and Environmental Services lead a 10 person AIS steering committee (AIS budget attached)

*2015 Lake Assoc. grant program for Inspections and education

*Purchased 3 decontamination units

*Hired 24 AIS inspectors (through Employment Resources, Inc.)

*Monitored 16+ public landings

*The inspectors are: EDUCATIONAL AND HELPFUL!

*Lynn Pribbenow scheduled and led all the inspectors

*Conducted 8,200+ boat inspections (about 7,418 hours)

*Similar plans for 2016 with some adjustments based on what we have learned in 2015

*In September our inspector Kyle Daun stopped a boat from launching in Big Sandy (6' X 3' area of the hull had live Zebra Mussels)

*We have very good law enforcement support

For more info: Steve Hughes, Aitkin Co. SWCD 927-6565

Aitkin County AIS Budget (Draft)					
Annual budget					
Task		% budget	spent	$	
Education		10%		$ 27,791.30	
Inspections		60%		$ 166,747.80	$ 194,539.10
Enforcement		10%		$ 27,791.30	
Emergency Response		3%		$ 8,337.39	
Decontamination		5%		$ 13,895.65	
Maintenance Fund		5%		$ 13,895.65	
Admin/Coordination		7%		$ 19,453.91	
Total		100%	$ -	$ 277,913.00	
startup (1st year)					
decon. units		$ 60,000.00			
traffic counters		$ 5,000.00			
equip. (inspectors)		$ 4,000.00			
equip. enforcement		$ 30,000.00			
emergency response		$ 5,000.00			
Maintenance, other		$ 21,061.00			
Total		$ 125,061.00	$ -		

Gmail

Steve Hughes <hughes.aitkinswcd@gmail.com>

Big Sandy Lake Incident

8 messages

Gorecki, Robert (DNR) <robert.gorecki@state.mn.us> Wed, Sep 30, 2015 at 2:34 PM
To: "sturner@co.aitkin.mn.us" <sturner@co.aitkin.mn.us>, "hughes.aitkinswcd@gmail.com" <hughes.aitkinswcd@gmail.com>, "jdrahota@co.aitkin.mn.us" <jdrahota@co.aitkin.mn.us>
Cc: "Provost, Tom (DNR)" <tom.provost@state.mn.us>

Sheriff Turner,

I am writing to express my appreciation for the efforts by one of your County Watercraft Inspectors: Kyle Daun.

A few weeks ago, Kyle was working the Public Access off of Hwy 65 on Big Sandy Lake when a truck and trailer pulled into the access to launch for the weekend. Kyle inspected the watercraft, and discovered a patch of Zebra Mussels approximately 6' long by 3' wide on the bottom of the boat. The driver informed him that he docks the boat on the Mississippi River on the MN/WI border all summer (which is an infested river) and was just up for the weekend after taking off the river the day before. Kyle informed him of the issue (as if he didn't know that they were there), and directed him to Willy's Marina to get his boat decontaminated. The driver complied, and left the access without launching. He then followed up with a call to his supervisor and me after taking a few photos of the zebra mussels. The operator was later fined for transporting invasive species.

I have no doubt, that if Kyle wouldn't have been there, live zebra mussels would have been introduced to one of your counties finest lakes and would have irreparably changed the lake for the worse.

Thank you for all your efforts in preventing and slowing the spread of these invasive species.

1Lt. Robert Gorecki-K290

District 10 Supervisor-Mille Lacs

MN DNR-Division of Enforcement

Handout SA

AITKIN COUNTY ADMINISTRATION

Aitkin County Courthouse
Nathan Burkett, Administrator
217 Second Street N.W. Room 130
Aitkin, MN 56431
218-927-7276
Fax: 218-927-7374

TO: County Board

FROM: Nathan Burkett NB

CC:

DATE: October 27, 2015

RE: Employee health insurance options

As requested by the County Board staff has continued to pursue the Hybrid employee health insurance option. This memo outlines what we have done, and the action we need from the Board at today's meeting if we are to make the change to the hybrid option.

Action on these items are needed today as we have to prepare for open enrollment either through NESC or with the hybrid plan (or both, depending). We are up against a deadline to get statements of benefits to employees per regulation.

Staff actions taken

1. Further analyzed the projection of rates for the hybrid plan and estimates of the choices employees will make (single, single +1 and family)
2. Met with both AFSCME units and non-union staff (2x) and discussed the hybrid proposal
    a. Proposal made to the bargaining units and shared with non-union staff is attached to this memo.
    b. AFSCME groups are choosing whether or not to bring the proposal to a vote of their members
3. Resolved questions brought forth by AFSCME and non-union staff to the greatest possible level
    a. Concerns related to employees who have reached age 65 and are Medicare eligible
    b. Concerns related to the interaction of VEBA, HSA and Flex spending accounts
    c. Received 3 specific statements from non-union employees that they do not want the Board to adopt the hybrid plan.
4. Obtained a working agreement with Nexben to share risk related to the adoption of the hybrid plan

Staff suggestions

1. The Board should consider the resolution which outlines the hybrid plan and it's compliance with the ACA closely to determine if the Board agrees with its stated findings.
2. The board should consider the cost risks related to the hybrid plan
    a. The projected rates and how they are created
    b. The projected selections of employees and how they were arrived at

Action needed if the Board wishes to adopt the hybrid

1. Adopt the proposed resolution with/without changes which:
    a. outlines why the board believes the hybrid plan is compliant
    b. grants authority to the county administrator to execute the agreements necessary with Nexben to move toward open enrollment within parameters
    c. grants authority to the county administrator to finalize the hybrid plan documents, the deferred comp, and the cafeteria plan documents as needed within parameters
    d. grants authority to the county administrator to execute MOAs with the AFSCME Courthouse and AFSCME HHS units
    e. grants authority to the county administrator to update the personnel policy to reflect necessary changes related

Whereas, the Aitkin County Board of Commissioners desires to offer health care coverage for Aitkin County employees that is affordable and effective for the employees and the employer in compliance with the provisions of the Patient Protection and Affordable Care Act (hereafter "ACA"); and

Whereas, the Aitkin County Board of Commissioners has observed an average annual premium increase of 10% in the County's current employee health insurance plan for the 10 year period of 2003 - 2016; and

Whereas, the Aitkin County Board of Commissioners has observed and believes it is reasonable to presume that the 10% growth trend in employee health care expenses will continue for the foreseeable future; and

Whereas, at the current growth trend it is reasonable to presume that the current Aitkin County group health plan will be subject to the ACA "Cadillac Tax" upon enforcement of said tax, and estimates that the County would be subject to a tax of approximately $88,000 annually; and

Whereas, premiums for Family health care plans on the Aitkin County group health insurance plan range from 11% to 29% of the average Aitkin County Employee's annual income; and

Whereas, the Aitkin County Board of Commissioners has reviewed an option to provide employee health benefits named the "Hybrid Plan" and made comparisons to the current group plan and considered the requirements of the ACA.

Now therefore be it resolved the Aitkin County Board makes the following findings:

1. Due to the high premiums of the plan, the current Aitkin County employee group health plan, while meeting the basic requirements of the ACA, does not meet the spirit of the ACA which is to ensure that employees of the County have access to affordable and effective health care coverage; and

2. An employee eligible for coverage under the Hybrid Plan has greater flexibility with respect to his or her "total" health coverage (i.e., through Aitkin County's group health plan in combination with coverage available outside Aitkin County's group health plan) than is available under the current Aitkin County employee group health plan, including but not limited to breadth of coverage (e.g., premium costs, network selection, deductible and co-pay specifics); and

3. The Hybrid Plan satisfies the applicable mandates of ACA, including but not limited to preventive care, age of dependent child, rescission, and enhanced claims and appeals procedures; and

4. The Hybrid Plan qualifies as "minimum essential coverage" (MEC) for purposes of ACA, including but not limited to part (a) of the Employer Shared Responsibility provisions; and

5. The list of covered expenses under the Hybrid Plan includes preventive care, as required under ACA, and the payment of the premium for an individual insurance policy; and

6. The Hybrid Plan is not an "employer payment plan" as defined in, and precluded by, IRS Notice 2013-54. The Hybrid Plan is not a health reimbursement arrangement (HRA). The Hybrid Plan is a defined benefit, self-insured medical plan fully operating within the employer sponsored group health plan environment, including but not limited to compliance with applicable ACA mandates such as preventive care; and

7. The Hybrid Plan is being offered to employees as a single, single +1 or family plan without regard to any other demographic factor or health history in compliance with the ACA.

Be it further resolved that the Aitkin County Board:

1. Hereby adopts the Hybrid plan effective January 1, 2016; and

2. Authorizes the County Administrator to finalize plan documentation necessary to put the intentions of the Aitkin County Board, as reflected in these Resolutions, into full effect for 2016; and

3. Authorizes the County Administrator to engage in an MOU with bargaining units in accordance with the intent of this resolution; and

4. Authorizes the County Administrator to engage in an agreement to utilize Nexben Inc's technology platform and insurance services; and

5. Authorizes the County Administrator to engage in a risk sharing agreement with Nexben, Inc.

AITKIN COUNTY ADMINISTRATION

Aitkin County Courthouse
Nathan Burkett, Administrator
217 Second Street N.W. Room 130
Aitkin, MN 56431
218-927-7276
Fax: 218-927-7374

TO: AFSCME Bargaining Units

FROM: Nathan Burkett

CC: Bobbie Danielson

DATE: 10/20/15

RE: Hybrid Health Insurance Plan Proposal

Following our discussion yesterday the County makes the following proposal. All proposals are contingent upon the approval of the Aitkin County Board of Commissioners.

Plan	Employee Monthly Contribution	Employer HSA Contribution (Annual)
$2000 Deductible; Single	$0	$1,000
$6550 Deductible; Single	$0	$2,700
$4000 Deductible; Employee +1	$390.00	$2,000
$13100 Deductible; Employee +1	$100.00	$3,000
$4000 Deductible; Family	$590.00	$3,000
$13100 Deductible; Family	$200.00	$4,000
Waive Coverage (must provide proof of coverage through another source, which may not be the public health care exchange)		$3,350

Medicare Eligible employees

The county will contribute the actual amount of Medicare premium and a supplement totaling up to $645 per month for employees who have reached the age of 65 and are Medicare eligible. For Medicare eligible employees who have family they wish to cover – the County will provide insurance for the employee contribution rates above.

	Employee Paid Premium (Monthly)	Employee Paid Premium (Annual)	HealthSav Contribution	Max OOP	Employee Worst Case
Existing Plans					
VEBA 100					
Single	146.00	1,752.00	1,000.00	1,850.00	2,602.00
Family	1,214.50	14,574.00	2,000.00	3,700.00	16,274.00
Veba 80					
Single	6.50	78.00	1,540.00	3,500.00	2,038.00
Family	818.50	9,822.00	3,260.00	6,500.00	13,062.00
HDHP					
Single	-	-	1,540.00	5,000.00	3,460.00
Family	496.00	5,952.00	3,260.00	10,000.00	12,692.00
Waiver	-	-	-		
Hybrid Plans					
2000/4000 - 100%					
Single	-	-	1,000.00	2,000.00	1,000.00
Single +1	390.00	4,680.00	2,000.00	4,000.00	6,680.00
Family	590.00	7,080.00	3,000.00	4,000.00	8,080.00
6550/13100 - 100%					
Single	-	-	2,700.00	6,550.00	3,850.00
Single +1	100.00	1,200.00	3,000.00	13,100.00	11,300.00
Family	200.00	2,400.00	4,000.00	13,100.00	11,500.00
Waiver			3,350.00		

COST SHARING AGREEMENT

This agreement, dated October ____, 2015 (the "Effective Date"), summarizes the basic terms of a cost sharing agreement (the "Agreement") between Nexben, Inc., a Delaware corporation ("Nexben"), and Aitkin County, Minnesota ("Aitkin").

Background

Nexben owns and operates a technology platform for quoting, selling and enrolling individuals and groups in health insurance and ancillary non-medical benefits (the "Platform"). The Platform includes software tools that employers use to streamline management of those benefits for their employees. Aitkin desires to be a Nexben client so that it can utilize the Platform for the administration of its employees' health and non-medical benefits, subject to the terms of this Agreement.

Hybrid Health Plan

The Platform is capable of administering and supporting the "Hybrid Health Plan," an arrangement whereby a self-insured group plan is "wrapped" around fully-insured ACA-compliant individual policies. Based on Aitkin's current group premiums, both parties believe that the Hybrid Health Plan will substantially lower Aitkin's health insurance costs while maintaining equivalent or superior benefits for its employees. Although the parties agree the risk is low, Aitkin's one concern is that it could incur penalties if the US Department of Health and Human Services ("HHS"), US Department of the Treasury, US Department of Labor or any other agency with the authority to assess penalties deems the Hybrid Health Plan to be non-compliant with the Affordable Care Act ("ACA").

Nexben's Share of Potential Penalties

Subject to the terms below, Nexben agrees to pay 50% of any penalties ~~HHS levies~~levied against Aitkin, which are directly attributable to Aitkin's use of the Hybrid Health Plan, up to a maximum of $80,000 ("Nexben's Share"). ~~Payment of Nexben's Share is contingent on the penalties being final and non-appealable. If there is an opportunity to appeal the penalties, Aitkin agrees to use its commercially reasonable efforts to appeal the penalties and~~ Aitkin is not required to appeal penalties, but may exercise any right to appeal. Should Aitkin choose to appeal, Nexben agrees to provide all reasonable support and assistance in making the appeal(s). Aitkin agrees to allow Nexben to appeal penalties on Aitkin's behalf should Nexben choose to do so. Aitkin is not obligated to allocate any resources to support an appeal made soley by Nexben on Aitkin's behalf. Payment of Nexben's share is contingent on Nexben and Aitkin choosing not to pursue further appeal or penalties are final and non-appealable. ~~Nexben agrees to provide all reasonable support and assistance in making the appeal(s).~~

Escrow

To satisfy a portion of Nexben's Share, Nexben agrees to hold $80,~~31,~~000 in escrow (the "Escrow Amount") upon Aitkin's execution of this Agreement and any agreements required to fully onboard Aitkin as a Nexben client. Nexben agrees to provide Aitkin proof of the Escrow Amount. At any point in time, Nexben can replace up to $40,000 of the escrow amount with a letter of credit or equivalent instrument.

Comment [A1]: I would have concerns without the funding being $80k or a letter of credit for the remainder from a long standing business or individual with verifiable assets.

Comment [A2]: I would like these to be defined more clearly.

Balance of Nexben's Share

To the extent the Escrow Amount is insufficient to cover Nexben's Share, Nexben agrees to pay Aitkin the remainder of Nexben's Share in 12 equal monthly installments.

Term

This term of this Agreement is 24 months from the Effective Date (the "Term"). ~~Nexben will only be obligated to pay Nexben's Share of penalties that are levied within the Term and are otherwise subject to the terms of this Agreement.~~ Nexben will be obligated to pay Nexben's share of penalties that are:

(a) levied at any time during the term of this agreement; or

(b) levied as a result of a notice received during the term of this agreement; or

(c) levied as a result an audit commenced during the term of this agreement

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Counterparts

This Agreement may be executed in counterparts, each of which will be deemed an original and taken together will constitute one document. PDF files delivered electronically will be deemed originals.

The parties have executed this agreement as of the Effective Date.

NEXBEN, INC.	**AITKIN COUNTY**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

nexben

INSURANCE AND TECHNOLOGY

SERVICE AGREEMENT

BY AND BETWEEN

AITKIN COUNTY, MINNESOTA

AND

NEXBEN, INC.

EFFECTIVE OCTOBER 1, 2015

THIS NEXBEN, INC. AGREEMENT (this "Agreement") is entered into as of November 1, 2015 (the "Effective Date"), by and between Aitkin County, Minnesota ("Employer"), a public entity and Nexben, Inc. a Delaware corporation.

RECITALS

WHEREAS, Nexben, Inc. is an Insurance Agency and Employee Benefits Consulting Firm who markets and distributes the Nexben technology platform. The Employer may implement the Nexben technology to administer their employee benefits program. The administration of benefits through Nexben and its imbedded Employer Private Insurance Exchange, allows for the enrollment, recording and management of employee benefit selections from a range of benefits selected by the Employer, all online.

WHEREAS, subject to the terms and conditions of this Agreement, Nexben, Inc. desires to grant to Employer, and Employer desires to accept, the right to implement Nexben technology platform for the purposes of administering the Employer provided Benefits Program. In doing so, the administration utilizing the Nexben technology facilitates an online employee benefits enrollment, where each eligible employee of the employer will be allowed to quote, shop and enroll for benefit options from the predetermined portfolio of products. The use of Nexben technology is contingent upon the ongoing status of Nexben, Inc. being appointed and retaining the status as Agent of Record (AOR) for medical insurance benefit products and programs made available through employer to employees. Commission earned on the medical insurance products is the means for how Nexben Insurance Services is compensated for services. Nexben, Inc. waives the technology administration fees and considers the commission as payment. Should commission payments not be payable for any reason a separate schedule of administrative costs are noted in the Administrative Fee section.

AGREEMENT

RIGHT of USE

a. Right of Use. Subject to all the terms and conditions herein (including the naming of Nexben, Inc. as the Agent of Record for Employer medical insurance employee benefits programs), Nexben hereby grants to Employer, and Employer accepts, a non-exclusive, non-transferable right to utilize Nexben technology to administer the employer benefit program. The employer benefits program administered through the Nexben technology platform will be utilized by employees for benefit shopping and enrollment and by employer for management of employee information, benefit data, HR tools and ACA compliance and reporting requirements.

OWNERSHIP and RETAINED RIGHTS

a. Nexben Product and Program. As between Employer and Nexben, Nexben owns all right, title and interest in and to the software application Nexben. This includes all documentation, analyses, reports, materials and all Intellectual Property Rights. Employer agrees not to contest Nexben's ownership of Nexben365 and Employer hereby assigns to Nexben any rights it may obtain.

FINANCIAL TERMS

a. Agent of Record Requirement. The use of the Nexben technology is contingent upon the ongoing status of Nexben, Inc. being appointed and retaining the status as Agent of Record (AOR) for medical insurance employee benefit products and programs made available through employer to employees during the time Nexben technology is utilized by Employer. Employer shall appoint Nexben, Inc. as Agent of Record for commission generated from medical insurance benefits through Insurance carriers and Health Plans and/or assign Consulting Fees otherwise payable (Consulting fees that are often a part of a self-funded medical plan must be discussed and agreed upon in advance).

TERM of AGREEMENT

a. Term. This Agreement shall commence on the Effective Date and continue for one-year periods, automatically renewing unless terminated by either party with a 30 day written notice.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives below as of the Effective Date.

NEXBEN INSURANCE SERVICES	AITKIN COUNTY, MINNESOTA
By:_____	By:_____
Name: Ben Rasmussen	Name:_____
Title: CEO	Title: _____

Contact Information:

Nexben Insurance Services
120 South 6th Street, Suite 1510
Minneapolis, MN 55402

Toll free: 1-866-647-7707
Direct: 612-361-1992
Fax: 612-238-3112

www.nexben.com

HITESMAN&WOLD P.A.

12900 – 63rd Avenue North
Maple Grove, MN 55369

Office: 763.503.6620
Fax: 763.503.6619
www.HitesmanLaw.com

Insight. Innovation. Ideas.

MEMORANDUM

TO: John Kelley & Ben Rasmussen, NexBen.

FROM: Darcy L. Hitesman, Esq.

DATE: October 16, 2015

RE: Individual Policies and Employer Payment Plans

Health Care Reform ("HCR") operates to amend a number of existing bodies of federal law, including the Internal Revenue Code ("Code"), ERISA, and the Public Health Services Act ("PHSA"). The substantive requirements of HCR are incorporated into each. But the enforcement mechanisms differ between the bodies of law. ***It is extremely important to identify the particular body of federal law in evaluating potential risks of enforcement.***

With respect to non-Federal governmental entities (e.g., a County), the market reform requirements of HCR are incorporated into Section 2723 of the PHSA. To the extent there is a failure in meeting these requirements, enforcement is accomplished by the Secretary of Health and Human Services through Section 42 U.S.C. 300gg-22(b).

In order for the Secretary of Health and Human Services to impose a civil assessment on the County under Section 300gg-22(b), there must be "a failure" with respect to the market reforms. In this case, there is no failure. The hybrid plan does not fail any of the applicable HCR market reforms.

There has been considerable attention paid to the individual premium aspect of the hybrid plan. IRS guidance identified an arrangement in IRS Notice 2013-54 (described below) and labeled it an "employer payment plan." The IRS guidance specifically determined that such an arrangement would not include the applicable market reforms; consequently, there would be a failure on the part of the arrangement. However, as described below, the hybrid plan is significantly different from what the IRS guidance labels an "employer payment plan" which by definition fails to address the applicable market reforms. ***By design***, the hybrid plan ***does*** meet the applicable market reforms; it does not fail to address the applicable market reforms. Absent a failure, there cannot be a civil assessment under 42 U.S.C. Section 300gg-22(c).

Summary of IRS Notice 2013-54

IRS Notice 2013-54 provides guidance regarding the application of certain provisions of ACA on certain types of arrangements – HRAs, employer payment plans, and health FSAs. The descriptive paragraph regarding employer payment plans provides no criteria, factors to consider, etc., in analyzing whether a particular arrangement is, or is not, an employer payment plan. Rather, the employer payment plan descriptive paragraph refers to Rev. Rul. 61-146 that addresses the tax consequences of an employer payment of individual policy premiums in a non-employer sponsored environment.

Unlike the situation addressed in Rev. Rul. 61-146 and the situation to which IRS Notice 2013-54 refers, the hybrid plan operates entirely within the employer sponsored environment. It is a self-insured medical plan. It does not need Rev. Rul.61-146 to make payments not taxable. Rather, the hybrid plan relies upon Section 105 so that the payments made by the self-insured medical plan, including the premium for individual insurance policies, are not included in the recipient's taxable income.

The distinct nature of the hybrid plan is further supported by Q&A-3 of that same Notice. Question 3 asks in part the following:

> "May a group health plan [. . .] used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the preventive services requirements?"

Answer 3 in part responds with the following:

> "No. [. . .] For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for a group health plan. ***However, the employer payment plan will fail to comply with the preventive services requirements*** because (1) an employer payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual insurance policy purchased under the arrangement." *Emphasis added.*

Clearly, the hybrid is not "an employer payment plan" because it ***does*** provide the preventive care services as required by the market reforms. And, there is no attempt to integrate the hybrid plan with the benefits provided through the individual policy. The hybrid plan has as a covered expense the premium for the policy, not the benefits available as a result of the policy. [That is why the hybrid plan does not provide at least 60% minimum value and, therefore, the employer sponsor remains exposed for potential shared responsibility payments under category (2) of the Play or Pay provisions.] The hybrid is not what the employment plan guidance intended to reach.

Civil assessment analysis.
The following scenarios represent the potential points at which an employer has risk:

1. Consistent with the analysis described above, there is no failure that triggers review by the Secretary of Health and Human Services. 42 U.S.C. Section 300gg-22(b)(2)(A) provides in part:

> "[A]ny non-Federal governmental plan that is a group health plan . . . that ***fails*** to meet a provision of this part applicable to such plan . . . is subject to a civil penalty under this subsection." *Emphasis added.*

In addition –

> "[T]he maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such ***failure*** occurs." *Emphasis added.*

42 U.S.C. Section 300gg-22(b)(2)(C)(i).

2. If there arguably is a failure of the HCR market reforms, the Secretary has parameters within which to operate regarding the amount of the civil assessment.

3. If there arguably is a failure of the HCR market reforms, in determining the amount of such assessment, the Secretary is ***required*** to consider the gravity of the violation. 42 U.S.C. Section 300gg-22(b)(2)(C)(ii).

4. If there arguably is a failure of the HCR market reforms, the Secretary cannot impose a penalty if certain circumstances exist.

> a "***No civil monetary penalty shall be imposed*** under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed know, or exercising reasonable diligence would have known, that such failure existed." *Emphasis added.*
>
> b "***No civil monetary penalty shall be imposed*** under this paragraph on any failure if such failure was due to reasonable cause and not willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed." *Emphasis added.*

42 U.S.C. Section 300gg-22(b)(2)(C)(iii)(II).

AITKIN COUNTY
HYBRID HEALTH CARE PLAN
PLAN DOCUMENT
and
SUMMARY DESCRIPTION

Prepared by:
Hitesman & Wold, P.A.
12900 - 63rd Avenue North
Maple Grove, MN 55369
Phone: 763-503-6620

TABLE OF CONTENTS

ARTICLE I.
INTRODUCTION

Aitkin County (the "Employer" or "Plan Sponsor") has established the Aitkin County Hybrid Health Care Plan (the "Health Plan") in order to provide healthcare benefits for Eligible Employees and their Dependents. The effective date of this Health Plan is January 1, 2016.

Note: Words and phrases appearing in initial capital letters are defined terms. The complete definitions appear in the *Definitions Article* that appears at the end of this document. You are encouraged to consult the *Definitions Article* of this document.

Nature of the Health Plan

This Health Plan is not an employee welfare plan for purposes of ERISA because the Health Plan is a governmental plan within the meaning of Section 3(32) of ERISA. Any resemblance of the Health Plan to an ERISA plan shall not bind the Health Plan to comply with ERISA. This Health Plan is a self-funded medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Code so the portion of the cost for coverage paid by the Employer is not taxable income to the Covered Individual and any benefits received through this Health Plan are not taxable income to the Covered Individual.

IMPORTANT: This Health Plan is ***NOT*** a Health Reimbursement Arrangement ("HRA") under IRS Revenue 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

Other things to note about the nature of the Health Plan Include:

- This Health Plan is "self-funded," which means Benefits are paid from the Employer's general assets.
- This Health Plan is a group health plan for purposes of HIPAA and shall be administered in a manner consistent with HIPAA.
- This Health Plan provides minimum essential coverage ("MEC") for purposes of Health Care Reform.

The Plan Administrator of this Health Plan retains ultimate authority for this Health Plan and also processes Claims, manages the operation of the Health Plan, and answers certain benefit and Claims questions. The Employer is the Plan Administrator.

Written Document and Summary Description

IMPORTANT: This document serves as both the written plan document and the summary description.

It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under this Health Plan. The document should be read in its entirety because many of its provisions are interrelated.

Scope of Coverage & Maximizing Coverage
This Health Plan does not provide for or pay all medical expenses. It pays ***certain*** expenses under ***certain*** circumstances.

For an expense to be "covered" under this Health Plan, a number of requirements must be met, Including:

(a) The person must be a Covered Individual;

(b) The service/product giving rise to the expense must be a Covered Service; and

(c) The expense for the Covered Service must meet the requirements of a Covered Charge.

This document provides you with the information necessary to determine whether and to what degree a particular expense is "covered" under this Health Plan and, therefore, the financial responsibility of this Health Plan.

Questions
Questions relating to this Health Plan should be directed to:

Aitkin County
Attn: Bobbie Danielson, HR Director
217 2nd Street NW, Room 134
Aitkin, MN 56431
Phone: 218-927-7306
Email: bobbie.danielson@co.aitkin.mn.us

New Rescission of Coverage Rules. Under this Health Plan, coverage may be retroactively cancelled or terminated (Rescinded) if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements Including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, Including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

ARTICLE II.
SUMMARY

2.1 **How to Use This Document.** This document consists of several parts. All of the parts of this document work together. The *Introduction Article* provides a variety of information a person covered under this Health Plan should know. This *Summary Article* provides an overview of key provisions of this Health Plan, Including the *Benefits Schedule.* Together with the *Definitions Article* that appears at the end of this document, these Articles provide a good summary of what is available through this Health Plan. In many cases, there will not be a need to look anywhere else. However, when a Covered Individual has a particular question regarding a particular expense, the more detailed description(s) that appear later in this document should also be reviewed. The *Summary Article* contains numerous references to other portions of the Health Plan. In addition, the Table of Contents can be used as an index to specific topics discussed throughout the document.

2.2 **Benefits Schedule.**

Note: This *Benefits Schedule* is a snapshot of the terms and conditions of the Benefits portion of this Health Plan. It is not intended to be comprehensive. Detail regarding each of these items is in the later text.

(a) **Preventive Care Benefits**

(1) Coverage for certain preventive care services;

(2) First dollar coverage; no cost sharing (i.e., no deductible or co-pay)

(3) Services must be provided by an In-network Provider

(4) No annual limit

(5) Health Plan pays this Benefit secondary to Other Coverage

(b) **Insurance Coverage Benefit**

(1) Select from menu of options

(2) Only certain specified coverages are eligible (see definition of "Eligible Individual Insurance Coverage" in Definitions Article)

(3) No annual limit

Note: The Benefit under this portion of the Plan is the premium, not the coverage items provided through the policy.

The two categories of Benefits are provided collectively; they are not provided as separate and independent Benefits. A Covered Individual must receive both types of Benefits. Failure to be covered under both Benefits results in coverage under no Benefits. Having Eligible Individual Insurance Coverage is an eligibility requirement.

Special Note: If for any reason an otherwise Eligible Employee does not have coverage and cannot be covered under the Insurance Coverage Benefit portion of the Plan, the Plan reserves the right to provide coverage on a limited basis under just the Preventive Care Benefit portion of the Plan.

2.3 **Amounts in Excess of Usual and Customary Rates.** When this Health Plan is responsible for a payment, it pays no more than the Usual and Customary Rates. If a Healthcare Provider charges more than the Usual and Customary Rates, the Covered Individual is responsible for the amount in excess of the Usual and Customary Rates.

2.4 **Claims Process.** In order for a Covered Charge to be paid by this Health Plan, a Claim must be properly and timely submitted. This Health Plan recognizes two (2) categories of Benefits, each with its own requirements for making a Claim:

(a) Preventive Care Benefits; and

(b) Insurance Coverage Benefit.

These are defined terms; more detail may be found in the *Definitions Article* that appears at the end of this document. Both types of Claims are considered "Post-Service Claims."

Very Important – Period Within Which to Make a Claim: For Insurance Coverage Benefit, a Claim must be made within sixty (60) days from the date the expense was Incurred. For Preventive Care Benefits, a Claim must be made within three hundred sixty-five (365) days from the date the expense was Incurred. It is the Claimant's responsibility to make sure a Claim is made in a timely manner.

2.5 **Making a Claim.**

(a) **Submission.** A Post-Service Claim must be written and submitted to the Plan Administrator.

(b) **Claim Form.** A Post-Service Claim for Covered Services should be filed on a form available from the Plan Administrator. The form will require, if applicable, at least the following information:

(1) the name of this Health Plan;

(2) the identity of the Claimant, Including name, address, and date of birth;

(3) the date(s) of service or coverage;

(4) identification of the Healthcare Provider or Insurance Carrier;

(5) for Preventive Care Benefits, a specific diagnosis code (current International Classification of Disease, Clinical Modification (IDC, CM) format);

(6) for Preventive Care Benefits, a specific service code for which payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format);

(7) the amount of billed charges;

(8) if the Claimant has already paid for the medical service or supply and is requesting reimbursement, proof of payment; and

(9) for Preventive Care Benefits, an Explanation of Benefits (EOB) from Other Coverage.

Note: Many of these items are built into the claim form available for the Plan Administrator. Some of these items will not be applicable for a Claim for Insurance Coverage Benefits.

(c) **Timing and Notification of Claims Decisions**. The time frames within which decisions must be made, whether formal notification shall be made, the details of any required formal notification, etc., are all described in *Addendum 1: Claim and Appeal Procedures* appearing later in this document.

(d) **Appeals and External Review**. If a Claimant does not agree with the initial Claim decision made by this Health Plan, the Claimant has a right to appeal that decision and have it reviewed. See the *Addendum 1: Claim and Appeal Procedures* appearing later in this document. And, if the Claimant does not agree with the Claim decision on appeal, the Claimant may have a right to request an External Review. See the *Addendum 1: Claim and Appeal Procedures* appearing later in this document.

(e) **Authorized Representative.** For purposes of this Health Plan's Claim And Appeals Procedures (described in *Addendum 1: Claim and Appeal Procedures* appearing later in this document), an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a Claim (or appeal). For Post-Service Claims, a completed Authorized Representative Form must be received by this Health Plan in order for this Health Plan to recognize a person as an Authorized Representative. Authorized Representative Forms are available from the Plan Administrator by request.

> **Note:** Recognition as an Authorized Representative is completely separate from a Healthcare Provider being an assignee of the Claimant. Assignment, and its limitations under this Health Plan, are described below.

2.6 **Subrogation, Reimbursement & Recovery.** In general, this Health Plan reserves the right to take action to make the Health Plan whole when another person is responsible for all or a portion of the Covered Services. This Health Plan also reserves the right to seek recovery if the Health Plan makes any payments in error, Including an error with respect to the amount paid or an error with respect to the party paid. These situations are described in more detail in the *Third Party Recovery, Subrogation & Erroneous Payment Article* that appears later in this document.

> **Important:** Cooperation with this Health Plan regarding these situations is a ***condition of coverage*** under the Health Plan.

2.7 **HIPAA Privacy Notification.** This Health Plan is a "covered entity" for purposes of HIPAA Privacy Rules and Security Rules. HIPAA requires that "covered entities" protect the confidentiality of your "protected health information." Protected health information means health information that:

(a) is created or received by a Healthcare Provider, health plan, or health care clearinghouse;

(b) relates to the past, present and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

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

This Health Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment and health plan operations, or as required by law. This Health Plan also requires its service providers, if any, to observe HIPAA's Privacy Rules and Security Rules.

Under HIPAA, you have certain rights with respect to your protected health information, Including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with

the Health Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

A complete description of your rights under HIPAA can be found in the Health Plan's privacy notice, distributed to you upon enrollment and available upon request from the Plan Administrator. In addition, detailed information regarding Health Plan operations and HIPAA compliance are described in the *HIPAA Privacy and Security Article* appearing later in this document.

2.8 **Continuation of Coverage.**

(a) **COBRA.** Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended and as conformed in the Public Health Services Act. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference. There shall also be compliance with state laws concerning continuation of coverage to the extent not preempted by federal law.

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

2.9 **Statement of Grandfathered Status Under Health Care Reform.** This Health Plan ***is NOT*** a "grandfathered health plan" under Health Care Reform. Questions regarding the Health Plan's status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

ARTICLE III.
ELIGIBILITY, EFFECTIVE DATE, TERMINATION PROVISIONS AND FUNDING

3.1 **Eligibility**. To be an Eligible Employee, an employee must have met the Eligibility Requirements for Employee Coverage (described below).

(a) **Eligibility Requirements for Employee Coverage.** In general, an individual employed by the Employer who has Eligible Individual Insurance and meets one of the following requirements is an Eligible Employee:

(1) **Regularly Scheduled Employee.** An employee scheduled to work a normal work week of thirty (30) hours or more per week.

(2) **Elected Official.** An elected official of the Employer who is also an employee because he or she is an elected official. There is no hours requirement for elected officials.

(3) **Other Employees**. For employees that do not fall within either of the above classifications, if the employee is offered coverage because he or she is deemed to be "full-time" for purposes of Health Care Reform.

(b) **Eligibility Requirements for Dependent Coverage.** A person is eligible for dependent coverage if he or she is any one of the following persons:

(1) A Covered Employee's Spouse. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A Covered Employee's child who less than twenty-six (26) years of age.

(3) Any child of a Covered Employee who is an alternate recipient under a medical child support order shall be considered as having a right to Dependent coverage under this Health Plan. A Covered Individual of this Health Plan may obtain, without charge, a copy of the procedures governing medical child support order determinations from the Plan Administrator.

(4) A Covered Employee's child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Health Plan must be furnished and approved by the Health Plan within thirty-one (31) days after the date the child attains the limiting age under the bullets above. The Health Plan may require, at reasonable intervals, subsequent proof satisfactory to the Health Plan.

An Eligible Dependent (e.g., Spouse, child of a Covered Employee, etc.) will become eligible for coverage under the Health Plan on the first day that the Eligible Employee becomes eligible for coverage and the Eligible Dependent satisfies the requirements for dependent coverage. If both mother and father are Covered Employees, any children will be covered as Dependents of the mother or father, but not of both.

Note: At any time, the Health Plan may require proof that a person qualifies or continues to qualify as an Eligible Dependent as defined by this Health Plan.

(c) **These Persons Do Not Meet the Definition of Eligible Dependent.**

(1) Other individuals living in the Covered Employee's home, but who are not eligible as defined above.

(2) The legally separated or divorced former Spouse of the Covered Employee.

(3) Any person who is covered under the Health Plan as a Covered Employee.

3.2 **Enrollment**

(a) **Enrollment Requirements**. An Employee must enroll for coverage by filling out and signing an enrollment application, Including providing proof of Eligible Individual Insurance, along with the appropriate payment authorization. If the Employee intends to cover any Eligible Dependents, those Eligible Dependents must also be affirmatively enrolled.

(b) **Enrollment Requirements for Newborn Children**. If the newborn child is not enrolled within thirty-one (31) days of birth, subsequent enrollment will be considered a Late Enrollment as described below.

VERY IMPORTANT: A newborn Child of a Covered Employee who already has Dependent coverage is ***not automatically enrolled*** in this Health Plan. A Covered Employee ***must affirmatively*** enroll the newborn child.

3.3 **Timely, Open, or Late Enrollment**

(a) **Timely Enrollment:** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two employees (husband and wife) are covered under the Health Plan and the employee who is covering the Eligible Dependent children terminates coverage, the Dependent coverage may be continued by the other Covered Employee with no Waiting Period as long as coverage has been continuous.

(b) **Open Enrollment:** Prior to the start of a Coverage Year, this Health Plan has an open enrollment period. "Open enrollment period" means the period of time occurring toward the end of the Coverage Year during which (1) Eligible Employees who are not covered under this Health Plan may elect to begin coverage effective the first day of the upcoming Coverage Year, and (2) Covered Employees will be given an opportunity to change their coverage effective the first day of the upcoming Coverage Year. The terms of the open enrollment period, Including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an open enrollment period.

(c) **Late Enrollment:** An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Eligible Dependents who are not eligible to join the Health Plan during a Special Enrollment Period may join only during a subsequent open enrollment period.

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

The time between the date on which a Late Enrollee first becomes eligible for enrollment under the Health Plan and the first day of coverage is not treated as a Waiting Period.

3.4 **Special Enrollment Rights**. Federal law provides Special Enrollment Rights under some circumstances.

(a) **Individuals losing Other Coverage creating a Special Enrollment Right.** An Employee or Eligible Dependent who is eligible, but not enrolled in this Health Plan, may enroll if loss of eligibility for Other Coverage meets all of the following conditions:

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

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

(3) The coverage of the Eligible Employee or Eligible Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(4) The Eligible Employee or Eligible Dependent requests enrollment in this Health Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(5) For purposes of these rules, a "loss of eligibility" occurs if one of the following occurs:

(i) The Eligible Employee or Eligible Dependent has a loss of eligibility on the earliest date a Claim is denied that would meet or exceed any applicable Health Plan limits.

(ii) The Eligible Employee or Eligible Dependent has a loss of eligibility due to the Other Coverage no longer offering any benefits to a class of similarly situated individuals (e.g., ceasing to cover part-time employees).

(iii) The Eligible Employee or Eligible Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as an Eligible dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Eligible Employee or Eligible Dependent has a loss of eligibility when the Other Coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(v) The Eligible Employee or Eligible Dependent has a loss of eligibility when the Other Coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Not a Special Enrollment Situation. If the Eligible Employee or Eligible Dependent lost the Other Coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the Other Coverage), that individual does not have a Special Enrollment Right under this Health Plan.

(b) **New Dependents creating a Special Enrollment Right.** If:

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

(2) a person becomes an Eligible Dependent of that Employee through marriage, birth, adoption or placement for adoption,

then the Eligible Dependent (and if not otherwise enrolled, the Eligible Employee) may be enrolled under this Health Plan.

In the case of the birth or adoption of a child, the Spouse of the Covered Employee may also be enrolled as an Eligible Dependent of the Covered Employee if the Spouse is otherwise eligible for coverage. If the employee is not enrolled at the time of the event, the Eligible Employee must enroll under this Special Enrollment Period in order for any eligible Dependents to enroll.

Note: The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment Period, the Eligible Dependent and/or employee must request enrollment during this thirty-one (31) day period.

The coverage of the Eligible Dependent and/or Eligible Employee enrolled in the Special Enrollment Period will be effective:

(1) in the case of marriage, the first day of the first calendar month beginning after the date of the completed request for enrollment is received;

(2) in the case of an Eligible Dependent's birth, as of the date of birth; or

(3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(c) **Medicaid and State Child Health Insurance Programs.** An Eligible Employee or Eligible Dependent who is eligible, but not enrolled in this Health Plan, may enroll in this Health Plan if:

(1) The Eligible Employee or Eligible Dependent covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Eligible Dependent terminated due to loss of eligibility for such coverage, and the Eligible Employee or Eligible Dependent requests enrollment in this Health Plan within sixty (60) days after such Medicaid or State Child Health Insurance Program ("CHIP") coverage is terminated.

(2) The Eligible Employee or Eligible Dependent becomes eligible for assistance with payment of employee contributions to this Health Plan through a Medicaid or CHIP plan (Including any waiver or demonstration project conducted with respect to such plan), and the Eligible Employee or Eligible Dependent requests enrollment in this Health Plan within sixty (60) days after the date the Eligible Employee or Eligible Dependent is determined to be eligible for such assistance.

Note: If an Eligible Dependent becomes eligible to enroll under this provision and the Eligible Employee is not then enrolled, the Eligible Employee must enroll in order for the Eligible Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received.

Note: The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date on which a Special Enrollee first becomes eligible to enroll under the Health Plan as a Special Enrollee and the first day of coverage under the Health Plan is not treated as a Waiting Period.

3.5 **Effective Date of Coverage**

(a) **Effective Date of Eligible Employee Coverage.** An Eligible Employee will be covered under this Health Plan as of the first day of the calendar month following the date on which the employee becomes an Eligible Employee provided the Eligible Employee has satisfied the eligibility and enrollment requirements.

(b) **Effective Date of Dependent Coverage.** An Eligible Dependent's coverage will take effect on the day that the eligibility requirements are met; the Employee is covered under the Health Plan; and all eligibility and enrollment requirements are met.

3.6 **USERRA.** Special rules apply to those Eligible Employees whose coverage is reinstated following a leave of absence governed by the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Covered Individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave. For more information regarding USERRA rights, see the *Summary Article* of this document.

3.7 **Employee Termination of Coverage.** Employee coverage will terminate on the earliest of these dates:

(a) The date the Health Plan is terminated.

(b) The last day of the calendar month in which the Covered Employee ceases to be an Eligible Employee. This includes death or termination of employment of the Covered Employee. (See the

description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA.)

(c) The date on which the Covered Employee ceases to be covered under the Eligible Individual Insurance Coverage.

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

(e) If a Covered Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining Benefits under the Health Plan, then the Health Plan may either terminate coverage as of a date to be determined at the Health Plan's discretion, consistent with applicable law Including the rules regarding Rescission.

Except in certain circumstances, a Covered Employee may be eligible for COBRA continuation coverage. See the description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA.

3.8 **Coverage during a Family and Medical Leave Act (FMLA) Leave.** Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law Including the following: (a) during an FMLA leave of absence, coverage under this Health Plan shall be maintained on the same terms and conditions as the coverage would have been provided had the Covered Employee not taken the FMLA leave, (b) if Health Plan coverage lapses during the FMLA leave, coverage will be reinstated upon conclusion of the FMLA leave, and (c) coverage shall be reinstated only if the person(s) had coverage under the Health Plan when the FMLA leave began.

3.9 **Rehiring a Terminated Employee.** A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

3.10 **Employees on Military Leave.** Employees going into or returning from military service may elect to continue Health Plan coverage as mandated by USERRA under the following circumstances. These rights apply only to Eligible Employees and their Dependents covered under the Health Plan immediately before leaving for military service. For more details on USERRA rights, see the discussion Article in the *Summary Article* of this document.

Note: These rights apply only to Eligible Employees and their Eligible Dependents covered under the Health Plan immediately before leaving for military service.

3.11 **Termination of Dependent Coverage.** A Covered Dependent's coverage will terminate on the earliest of these dates:

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

(b) The date that the Covered Employee's coverage under the Health Plan terminates for any reason Including death. (See the description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA).

(c) The date a Covered Dependent Spouse ceases to be an Eligible Dependent as defined by the Health Plan. (See the description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA).

(d) The last day of the calendar month that a Covered Dependent child ceases to be an Eligible Dependent as defined by the Health Plan. (See the description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA).

(e) The date on which the Covered Individual ceases to be covered under the Eligible Individual Insurance Coverage.

(f) In the case of a child age twenty-six (26) or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

(1) Cessation of such inability;

(2) Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination;

(3) Upon the child's no longer being dependent upon the Covered Employee for support.

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

(h) If an Eligible Dependent or Covered Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining Benefits under the Health Plan, then the Health Plan may terminate coverage as of a date to be determined at the Health Plan's discretion, consistent with applicable law including the rules regarding Rescission.

(i) For a Covered Dependent child whose coverage is required pursuant to a medical child support order, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Health Plan.

Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. See the description in the *Summary Article* of this document regarding Continuation Coverage Rights under COBRA.

3.12 **Rescission.** Coverage under this Health Plan may be Rescinded under certain circumstances. A determination by the Health Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Individual whose coverage is being Rescinded will be provided a thirty (30) day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the thirty (30) day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Health Plan. Claims Incurred after the retroactive date of termination that were paid under the Health Plan will be treated as erroneously paid Claims under this Health Plan.

3.13 **Funding.** For each Coverage Year, the Employer will determine the cost to the Health Plan of providing the Benefits and the amount of Covered Employee contributions, if any, that Covered Employees or any subgroup of Covered Employees will be required to pay for coverage under this Health Plan. The Employer will notify the Covered Employees of the applicable contribution he/she must make for coverage under the Plan. The portion of the cost of coverage for which the Covered Employee is responsible may be paid by the Covered Employee on a pre-tax basis through a cafeteria plan of the Employer if such a plan is made available by the Employer and the Covered Employee meets the eligibility requirements of the cafeteria plan.

(a) **Operating Expenses for this Health Plan.** Operating expenses may be paid either (1) out of Health Plan assets, if any, or (2) by the Employer.

(b) **Health Plan Assets.** To the extent this Health Plan has assets, such assets shall be used for the sole and exclusive purpose of providing Benefits under this Health Plan and defraying reasonable administrative costs of this Health Plan (Including disposition of Health Plan assets upon termination of this Health Plan).

(c) **No Trust.** There is no trust. Benefits under this Health Plan are paid from the general assets of the Employer.

ARTICLE IV.
HEALTH BENEFITS DESCRIPTIONS

Benefits are available under this Health Plan when Covered Charges are Incurred by a Covered Individual while the person is covered for these Benefits under the Health Plan. This Article is intended to be read in conjunction with the *Benefits Schedule* in the *Summary Article*.

4.1 **Covered Charges**. Covered Charges are those expenses Incurred for the following:

(a) **Preventive Care Benefits.** This Health Plan pays Preventive Care Benefits, in accordance with Health Care Reform, secondary to a Covered Individual's Other Coverage.

The following types of preventive care services are covered:

(1) Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF), Including blood pressure, diabetes, and cholesterol screenings; many cancer screenings; and screening and counseling regarding smoking, diet, depression, and alcohol use;

(2) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(3) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents, Including regular well-baby and well-child visits from birth to age 21; and

(4) Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women; Including contraceptive methods and counseling, breastfeeding support and supplies, and screening and counseling for interpersonal and domestic violence.

> **Note:** Detailed lists of the specific services in each of the four categories referenced above are found at https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Changes to the recommendations or guidelines referenced above become applicable to the Health Plan as of the Plan Year that begins one year or later after the recommendation or guideline is issued.

(b) **Insurance Coverage Benefit.** This Health Plan provides the Insurance Coverage Benefit through payment of premiums for Eligible Individual Insurance Coverage.

These charges are subject to the Benefit limits, exclusions and other provisions of this Health Plan. The cost of coverage to the Health Plan to provide the coverage Includes the cost of Preventive Care Benefits, Insurance Coverage Benefits, and reasonable administrative expenses.

4.2 **Cost of Coverage**. The cost of coverage under this Health Plan consists of the cost to the Health Plan to provide both categories of these Benefits.

4.3 **Benefits Package**. The two categories of Benefits are provided collectively; they are not provided as separate and independent Benefits. A Covered Individual must receive both types of Benefits. Failure to be covered under both Benefits results in coverage under no Benefits.

ARTICLE V.
HEALTH PLAN EXCLUSIONS

For all Benefits shown in the *Benefits Schedule*, the following is not a "Covered Charge":

(1) **Coordination of Benefits (COB).** Expenses that would be Covered Charges but for the application of the Coordination of Benefits provisions of this Health Plan.

(2) **Excess charges.** The part of an expense for care and treatment of an illness or injury that is in excess of the Usual and Customary Rate.

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

(4) **Illegal acts.** Charges for any illness or injury which is Incurred while taking part or attempting to take part in an illegal activity, Including misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (Including both physical and mental health conditions).

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

(6) **Immediate Family of Covered Individual.** Services, supplies, care or treatment rendered by a Covered Individual of the immediate family or person residing in the same household.

(7) **Incurred by Other Persons.** Services, supplies, care or treatment expenses actually Incurred by other persons.

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

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

(10) **No obligation to pay.** Charges Incurred for which the Health Plan has no legal obligation to pay.

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

(12) **Occupational.** Care and treatment of an illness or injury that is occupational that is, arises from, work for wage or profit Including self-employment.

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

(14) **Subrogation, Reimbursement, and/or Third Party Responsibility.** Of an illness or injury not payable by virtue of the Health Plan's subrogation, reimbursement, and/or third party responsibility provisions.

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

ARTICLE VI.
COORDINATION OF BENEFITS

6.1 **Coordination of Coverage Sources**. This Article sets out rules for the order of payment of Covered Charges when two or more sources of coverage are paying. When a Covered Individual is covered by this Health Plan and Other Coverage, the coverage sources will be coordinated when a Claim is received.

6.2 **Other Coverage.** This Health Plan pays second to Other Coverage. This Health Plan provides Benefits for Covered Charges only in the event and to the extent that a reimbursement or payment for a Covered Charge is not provided through Other Coverage, whether owned by the Employer, the Covered Individual, or another person. In the event there is Other Coverage in effect providing for reimbursement or payment, in whole or in part, for a Covered Charge, then the Covered Charge, or portion thereof, is not payable under this Health Plan. To the extent the Other Coverage provides in-network and out-of-network benefits, this Health Plan pays as if the Covered Charges were received from an In-Network Provider.

6.3 **Payment Order**. This Health Plan shall always be considered secondary to such Other Coverage.

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

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

6.6 **Right of Recovery.** Whenever payments have been made by this Health Plan in excess of the amount the Health Plan is required to make, the Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Health Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Health Plan determines are responsible for payment and any future Benefits payable to the Covered Individual.

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

6.8 **Workers' Compensation.** Coverage under this Health Plan is not in lieu of workers' compensation.

6.9 **Medicare.** Notwithstanding anything herein to the contrary, this Health Plan shall comply with the Medicare secondary payer rules.

ARTICLE VII.
THIRD PARTY RECOVERY, SUBROGATION & ERRONEOUS PAYMENT

Note: The provisions of this Article apply to the fullest extent allowed under applicable Minnesota law.

7.1 Condition of Payment

(a) The Health Plan, in its sole discretion, may elect to conditionally advance payment of Benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Individuals, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this Article as "Covered Individual(s)") or a third party, where any party besides the Health Plan may be responsible for expenses arising from an incident, and/or other funds are available, Including No-fault Auto Insurance, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Outside coverage").

(b) Covered Individual(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Health Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred (100%) percent of the Health Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Health Plan or the Health Plan's assignee. By accepting benefits the Covered Individual(s) agrees the Health Plan shall have an equitable lien on any funds received by the Covered Individual(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Individual(s) agrees to include the Health Plan's name as a co-payee on any and all settlement drafts.

(c) In the event a Covered Individual(s) settles, recovers, or is reimbursed by any coverage, the Covered Individual(s) agrees to reimburse the Health Plan for all benefits paid or that will be paid by the Health Plan on behalf of the Covered Individual(s). If the Covered Individual(s) fails to reimburse the Health Plan out of any judgment or settlement received, the Covered Individual(s) will be responsible for any and all expenses (fees and costs) associated with the Health Plan's attempt to recover such money.

(d) If there is more than one party responsible for charges paid by the Health Plan, or may be responsible for charges paid by the Health Plan, the Health Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Individual(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

(e) The Health Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Individual(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Health Plan's recovery will not be applicable to the Health Plan and will not reduce the Health Plan's reimbursement rights.

(f) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Health Plan and signed by the Covered Individual(s).

(g) This provision shall not limit any other remedies of the Health Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

7.2 **Subrogation**

(a) As a condition to participating in and receiving Benefits under this Health Plan, the Covered Individual(s) agrees to assign to the Health Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Individual(s) is entitled, regardless of how classified or characterized, at the Health Plan's discretion.

(b) If a Covered Individual(s) receives or becomes entitled to receive Benefits under this Health Plan, an automatic equitable lien attaches in favor of the Health Plan to any Claim, which any Covered Individual(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Health Plan plus reasonable costs of collection.

(c) The Health Plan may, at its discretion, in its own name or in the name of the Covered Individual(s) commence a proceeding or pursue a Claim against any party or coverage for the recovery of all damages to the full extent of the value of any such Benefits or conditional payments advanced by the Health Plan.

(d) If the Covered Individual(s) fails to file a Claim or pursue damages against:

(1) the responsible party, its insurer, or any other source on behalf of that party;

(2) any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

(3) any policy of insurance from any insurance company or guarantor of a third party;

(4) worker's compensation or other liability insurance company; or

(5) any other source, Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Individual(s) authorizes the Health Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Individual(s)' and/or the Health Plan's name and agrees to fully cooperate with the Health Plan in the pursuance of any such Claims. The Covered Individual(s) assigns all rights to the Health Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

7.3 **Right of Reimbursement**

(a) The Health Plan shall be entitled to recover one hundred (100%) percent of the Benefits paid under this Health Plan, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Individual(s) is fully compensated by his/her recovery from all sources. The Health Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Health Plan's equitable lien and right to reimbursement. The obligation to reimburse the Health Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates

the recovery or a portion of it as Including medical, disability, or other expenses. If the Covered Individual(s)' recovery is less than the Benefits paid under this Health Plan, then the Health Plan is entitled to be paid all of the recovery achieved.

(b) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Health Plan's recovery without the prior, expressed written consent of the Health Plan.

7.4 **Erroneous Payments**. To the extent payments made by this Health Plan with respect to a Covered Individual are in excess of the amount the Health Plan should have paid, the Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Health Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Health Plan determines are either responsible for payment or received payment in error, and any future Benefits payable to the Covered Individual.

7.5 **Excess Insurance.** Except as otherwise provided under the Health Plan's *Coordination of Benefits Article*, the following rule applies:

(a) If at the time of injury, illness, disease or disability there is available, or potentially available any Coverage (Including Coverage resulting from a judgment at law or settlements), the benefits under this Health Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Health Plan's Coordination of Benefits Article.

(b) The Health Plan's benefits shall be "excess" to:

(1) the responsible party, its insurer, or any other source on behalf of that party;

(2) any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

(3) any policy of insurance from any insurance company or guarantor of a third party;

(4) workers' compensation or other liability insurance company; or

(5) any other source, Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

7.6 **Separation of Funds.** Benefits paid by the Health Plan, funds recovered by the Covered Individual(s), and funds held in trust over which the Health Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect the Health Plan's equitable lien, the funds over which the Health Plan has a lien, or the Health Plan's right to subrogation and reimbursement.

7.7 **Wrongful Death**. In the event that the Covered Individual(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any outside coverage, the Health Plan's subrogation and reimbursement rights shall still apply.

7.8 **Obligations.**

(a) It is the Covered Individual(s)' obligation at all times, both prior to and after payment of medical benefits by the Health Plan:

(1) to cooperate with the Health Plan, or any representatives of the Health Plan, in protecting its rights, Including discovery, attending depositions, and/or cooperating in trial to preserve the Health Plan's rights;

(2) to provide the Health Plan with pertinent information regarding the sickness, disease, disability, or injury, Including accident reports, settlement information and any other requested additional information;

(3) to take such action and execute such documents as the Health Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(4) to do nothing to prejudice the Health Plan's rights of subrogation and reimbursement;

(5) to promptly reimburse the Health Plan when a recovery through settlement, judgment, award or other payment is received; and

(6) to not settle or release, without the prior consent of the Health Plan, any Claim to the extent that the Covered Individual may have against any responsible party or outside coverage.

(b) If the Covered Individual(s) and/or his or her attorney fails to reimburse the Health Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Individual(s) will be responsible for any and all expenses (whether fees or costs) associated with the Health Plan's attempt to recover such money from the Covered Individual(s).

(c) The Health Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Individual(s)' cooperation or adherence to these terms.

7.9 **Offset.** Failure by the Covered Individual(s) and/or his or her attorney to comply with any of these requirements described in this Article may, at the Health Plan's discretion, result in a forfeiture of payment by the Health Plan of medical benefits and any funds or payments due under this Health Plan on behalf of the Covered Individual(s) may be withheld until the Covered Individual(s) satisfies his or her obligation.

7.10 **Minor Status**

(a) In the event the Covered Individual(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Health Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(b) If the minor's parents or court-appointed guardian fail to take such action, the Health Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

7.11 **Severability.** In the event that any provision of this Article is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Article and Health Plan. The provision shall be fully severable. The Health Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been inserted in the Health Plan.

ARTICLE VIII.
HIPAA PRIVACY & SECURITY

8.1 **Compliance with HIPAA Privacy and Security Standards.** Certain members of the Employer's workforce perform services in connection with administration of the Health Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(a) **General.** The Health Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this *HIPAA Privacy & Security Article* is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, Including information about treatment or payment for treatment.

(b) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Health Plan administrative functions.

The Health Plan's administrative functions shall include all Health Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Health Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Health Plan that are related to quality assessment; evaluation, training or accreditation of Healthcare Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, Including stop-loss insurance; medical review; legal services or auditing functions; or business Health Planning, management and general administrative activities.

(c) **Authorized Employees.** The Health Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Health Plan. For purposes of this *HIPAA Privacy & Security Article*, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

In accordance with HIPAA, only the following employees or classes of employees may be given access to protected health information and electronic protected health information:

(1) 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

(2) staff designated by the person described in (1) above.

Important: (1) The persons described in above may only have access to and use and disclose protected health information for Health Plan administration functions that the Employer performs for the Plan; and (2) if the person described above does not comply with this Health Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary action against such person.

(d) **Updates Required.** The Employer shall amend the Health Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(e) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Health Plan.

(f) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, Including:

(1) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(3) Mitigating any harm caused by the breach, to the extent practicable; and

(4) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

8.2 **Certification of Employer.** Under the Privacy Rules, the Plan may not disclose protected health information 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 protected health information 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 protected health information to the Employer. The Employer agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Health Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Health Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Health Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to Covered Individuals or former Covered Individuals in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by Covered Individuals and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to Covered Individuals in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Health Plan available to the Department of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Health Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Health Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

ARTICLE IX.
PLAN ADMINISTRATOR

9.1 **Responsibilities of the Plan Administrator.** The Employer is the Plan Administrator. The Health Plan must be administered by the Plan Administrator. An individual may be appointed by the Employer to act on behalf of the Employer as the Plan Administrator. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Employer shall appoint a new Plan Administrator as soon as reasonably possible.

9.2 **Powers of the Plan Administrator**

(a) The Plan Administrator shall administer this Health Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures.

It is the express intent of this Health Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Health Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Individual's rights, and to decide questions of Health Plan interpretation and those of fact relating to the Health Plan.

To the maximum permitted under applicable law, the decisions of the Plan Administrator will be final and binding on all interested parties.

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

9.3 **Duties of the Plan Administrator.** The Plan Administrator will have the powers and duties of the general administration of this Health Plan, Including the following:

(a) To administer the Health Plan in accordance with its terms;

(b) To determine all questions of eligibility, status, and coverage under the Health Plan;

(c) To interpret the Health Plan, Including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(d) To make factual findings;

(e) To decide disputes which may arise relative to a Covered Individual's rights and/or availability of benefits;

(f) To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;

(g) To keep and maintain the Health Plan documents and all other records pertaining to the Health Plan;

(h) To appoint and supervise a Claims Administrator to pay Claims;

(i) To perform all necessary reporting as required by applicable law;

(j) To establish and communicate procedures to determine whether a medical child support order is valid;

(k) To delegate to any person or entity such powers, duties and responsibilities it deems appropriate; and

(l) To perform each and every function necessary for or related to the Health Plan's administration.

9.4 **Plan Administration Compensation.** The Plan Administrator serves without compensation; however, all expenses for Health Plan administration, Including compensation for hired services, will be paid by the Health Plan.

9.5 **Release of Medical Information.** The Plan Administrator and Claims Administrator are entitled to receive information reasonably necessary to administer this Health Plan, subject to all applicable confidentiality requirements as defined in this Health Plan and as required by law, from any Healthcare Provider of services to a Covered Individual. By accepting coverage under this Health Plan, Covered Individuals agree to sign the necessary authorization directing any Healthcare Provider that has attended or treated them, to release to the Plan Administrator and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Covered Individual. If the Covered Individual fails to sign the necessary authorization or otherwise inhibits the Plan Administrator and/or Claims Administrator from getting necessary information to pay Claims, this Health Plan has no obligation to pay Claims.

9.6 **Payment to Healthcare Providers and Assignment of Benefits.** A Covered Individual's right to receive payment hereunder is personal to that Covered Individual and may not be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for the debts or obligations of a Covered Individual, except for assignment of the right to receive benefits to a Healthcare Provider. With respect to any assignment to a Healthcare Provider, that Healthcare Provider is subject to the same terms and conditions under this Health Plan as the Covered Individual, Including Preventive Care Benefits under this Health Plan paying second to a Covered Individual's Other Coverage.

9.7 **Amending and Terminating the Health Plan.** The Plan Sponsor expects to maintain this Health Plan indefinitely; however, as the settlor of the Health Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Health Plan in whole or in part. This includes amending the benefits under the Health Plan.

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

If the Health Plan is terminated, the rights of the Covered Individuals are limited to expenses Incurred before termination. Benefits will be paid only for Covered Services Incurred prior to the termination date. All amendments to this Health Plan shall become effective as of a date established by the Plan Sponsor.

ARTICLE X.
GENERAL PROVISIONS

10.1 **Applicable Law.** This is a self-funded benefit plan coming within the purview of the Public Health Services Act. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

10.2 **Conformity with Governing Law.** If any provision of this Health Plan is contrary to any law to which it is subject, such provisions is hereby amended to conform thereto.

10.3 **Type of Administration.** The Health Plan is a self-funded group health plan and the administration is provided through the Plan Administrator. The funding for the Benefits is derived from the funds of the Employer and contributions made by Covered Individuals. The Health Plan is not insured.

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

10.5 **Legal Entity.** This Health Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

10.6 **Nondiscrimination Policy.**

(a) This Health Plan will not discriminate against any Covered Individual based on race, color, religion, national origin, disability, gender, sexual preference, or age. This Health Plan will not establish rules for eligibility based on health status, medical condition, Claims experience, receipt of healthcare, medical history, evidence of insurability, Genetic Information, or disability.

(b) This Health Plan is intended to be nondiscriminatory and to meet the requirements under applicable Sections of the Internal Revenue Code of 1986. If the Plan Administrator determines before or during any Health Plan year, that this Health Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code of 1986 or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Covered Employees, to assure compliance with such requirements or limitation.

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

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

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than

ninety-six (96) hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the treating Physician (e.g., your Physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other Healthcare Provider obtain authorization for prescribing a length of stay of up forty-eight (48) hours (or ninety-six (96) hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on pre-certification, contact your Plan Administrator.

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

10.10 **Genetic Information Nondiscrimination Act of 2008 (GINA).** Notwithstanding any provision of this Health Plan to contrary, this Health Plan shall be operated and maintained in a manner consistent with the GINA.

10.11 **Children's Health Insurance Program Reauthorization Act of 2009.** Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA").

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

10.13 **Family and Medical Leave Act of 1993.** Notwithstanding any provision of the Plan to contrary, the Plan shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder.

10.14 **Consolidated Omnibus Budget Reconciliation Act of 1985.** Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), and in accordance with any policies and procedures adopted by the Plan Administrator.

10.15 **Uniformed Services Employment and Reemployment Rights Act of 1994.** Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), and in accordance with any policies and procedures adopted by the Plan Administrator.

10.16 **Health Care Reform.** To the extent the Plan is subject to the requirements of Health Care Reform, the Plan shall be operated and maintained in a manner consistent with Health Care Reform.

ARTICLE XI.
DEFINITIONS

This Article defines the terms used in this Health Plan. These terms appear in initial capital letters throughout this Health Plan when referred to in the context defined.

Note: There may be other terms defined in specific Articles of this Health Plan that appear just in those Articles. Those terms may not be defined in this Article.

Adverse Benefit Determination: a denial, reduction or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit.

Authorized Representative: a person designated by the Claimant or this Health Plan to act on behalf of the Claimant.

Benefits: the Preventive Care Benefits and Insurance Coverage Benefit available through this Health Plan.

Benefits Schedule: the schedule listed in the *Summary Article* of the Health Plan summarizing the Benefits available under this Health Plan.

CHIP: the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time, Including the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claim: a submission to the Health Plan for payment under the Health Plan in accordance with the Health Plan requirements.

Claimant: a Covered Individual (or the Authorized Representative of the Covered Individual) who is entitled to and makes a Claim for benefits under the Health Plan.

Claims Administrator: the person or entity responsible for administering Claims. The Claims Administrator's responsibilities typically consist of initially determining the validity of the Claims and administering benefit payments under this Health Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Plan Administrator, Plan Sponsor, and Claims Administrator. The Plan Administrator may also perform responsibilities as a Claims Administrator without a contract.

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

Code: the Internal Revenue Code of 1986, as amended.

Covered Charge(s): the Reasonable charge, or portion of the charge, imposed (1) by Healthcare Providers for Healthcare Services eligible for payment under this Health Plan, or (2) by Insurance Carriers for Eligible Individual Insurance Coverage eligible for payment under this Health Plan.

Covered Dependent: an Eligible Dependent who is participating under this Health Plan in accordance with the *Eligibility, Effective Date, Termination Provision and Funding Article* and whose coverage has not terminated.

Covered Employee: an employee who is participating under this Health Plan in accordance with the *Eligibility, Effective Date, Termination Provision and Funding Article* and whose coverage has not terminated.

Covered Individual: a Covered Employee or Covered Dependent who is participating under this Health Plan in accordance with the *Eligibility, Effective Date, Termination Provision and Funding Article* and whose coverage has

not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Health Plan.

Covered Services: the Healthcare Services described in this Health Plan for which Benefits are payable, to the extent described in the Health Plan and unless otherwise limited or excluded by the Health Plan.

Eligible Dependent: an individual who meets the dependent eligibility criteria for this Health Plan as described in the *Eligibility, Effective Date, Termination Provision and Funding Article* and who has not ceased to meet the eligibility criteria.

Eligible Employee: an employee or former employee of the Employer who meets the eligibility criteria for this Health Plan as described in the *Eligibility, Effective Date, Termination Provision and Funding Article* and who has not ceased to meet the eligibility criteria.

Eligible Individual Insurance Coverage: medical insurance coverage that:

(a) is individual coverage issued by an Insurance Carrier;

(b) is purchased by or is the financial responsibility of the Employee;

(c) covers persons eligible to be Covered Individuals;

(d) provides at least sixty (60%) percent minimum value (as the term is defined in Health Care Reform); and

(e) is not purchased through a public exchange required to be established under Health Care Reform.

Employer: Aitkin County.

Enrollment Date: the first day of actual coverage under the Health Plan.

ERISA: the Employee Retirement Income Security Act of 1974, as amended. Governmental entities are not subject to ERISA.

External Review: Health Care Reform requires External Review be made available in certain circumstances under applicable state or federal procedures. The specifics of External Review are being determined through regulatory guidance. External Review decisions are binding on the Health Plan and Claimant except to the extent other remedies are available under applicable state and/or federal law.

FMLA: the Family and Medical Leave Act of 1993, as amended.

Health Care Reform: the provisions of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), applicable to the Health Plan.

Health Plan: the Employer's group health plan, as may be amended from time to time, consisting of this document. The Health Plan is known as the Aitkin County Hybrid Health Care Plan.

Healthcare Provider: institutional Healthcare Providers or professional Healthcare Providers providing Healthcare Services to Covered Individuals. Each Healthcare Provider must be licensed, registered or certified by the appropriate state agency where the Healthcare Services are performed. Where there is no appropriate state agency, the Healthcare Provider must be registered or certified by the appropriate professional body. Healthcare Provider Includes those listed below:

(a) **Advanced Practice Registered Nurse** - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife and Nurse Practitioner.

(b) **Ambulatory Surgical Facility** - a facility with an organized staff of Physicians that:

(1) has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and

(2) provides treatment by or under the direct supervision of a Physician or other Healthcare Provider; and

(3) does not provide inpatient accommodations; and

(4) is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

(c) **Audiologist**

(d) **Chiropractor** - a Doctor of Chiropractic (D.C.).

(e) **Dentist** – a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).

(f) **Durable Medical Equipment Healthcare Provider.**

(g) **Home Health Agency** - an agency that provides Home Health Care and that is Medicare certified and licensed or approved under state or local law.

(h) **Hospice** - an organization that provides medical, social and psychological services as palliative treatment for Covered Individuals with a terminal illness and life expectancy of less than six (6) months.

(i) **Hospital** – licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Physicians or other Healthcare Providers.

(j) **Licensed Practical Nurse (L.P.N.)**

(k) **Licensed Registered Dietician**

(l) **Occupational Therapist**

(m) **Optometrist** – a Doctor of Optometry (D.O.)

(n) **Physical Therapist**

(o) **Physician** – a Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.)

(p) **Physician Assistant** - an individual licensed by the medical examining board to provide medical care with Physician supervision and direction.

(q) **Podiatrists** - a Doctor of Podiatry (D.P.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Surgical Podiatry (D.S.P.).

(r) **Psychiatrist**

(s) **Psychologist**

(t) **Radiation Therapist**

(u) **Registered Nurse (R.N.)**

(v) **Respiratory Therapist**

(w) **Skilled Nursing Facility** - an institution or a distinct part of an institution providing Skilled Care and related services to persons on an inpatient basis.

(x) **Social Worker** - an individual who is qualified through education, training and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions or Substance Abuse when employed by, or under the supervision of, an M.D., D.O., or Ph.D.

(y) **Speech Pathologist**

(z) **Speech Therapist**

(aa) **Urgent Care Facility** - a clinic, acute care facility or walk-in clinic with Urgent Care hours or walk-in clinic hours providing treatment for Urgent Care.

Healthcare Services: services provided by a Healthcare Provider that constitute medical care under Section 213(d) of the Code.

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

Including: Including, but not limited to.

Incurred: a Covered Charge is Incurred on the date the service is rendered or the supply is obtained.

In-network Provider: a Healthcare Provider that is part of the Insurance Carrier's network of providers and is considered "in-network" under the Eligible Individual Insurance Coverage.

Insurance Carrier: an insurance carrier licensed to do business in the State in which the Eligible Individual Insurance Coverage is issued.

Insurance Coverage Benefit: payment of the cost of the Eligible Individual Insurance Coverage for Covered Individuals.

Late Enrollee: a Covered Individual who enrolls under the Health Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Health Plan or during a Special Enrollment Period.

Legal Guardian: a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

NMHPA: the Newborns' and Mothers' Health Protection Act.

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

Other Coverage: coverage Including:

(a) any primary payer besides the Health Plan;

(b) any other group health plan;

(c) any health coverage or policy covering the Covered Individual;

(d) any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

(e) any policy of insurance from any insurance company or guarantor of a responsible party;

(f) any policy of insurance from any insurance company or guarantor of a third party;

(g) workers' compensation or other liability insurance company; or

(h) any other source Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Physician: a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Administrator: the person or entity who retains ultimate authority for this Health Plan Including final appeal determinations. The Plan Administrator is the Employer.

Plan Sponsor: the Employer.

Plan Year: the period beginning on January 1st and ending on December 31st.

Post-Service Claim: any Claim for a benefit under this Health Plan that is submitted for payment or reimbursement after the services have been rendered.

Preventive Care Benefits: payment of the cost of Healthcare Services provided by an In-network Provider for the purpose of health maintenance, not for the treatment of an illness or injury, to the extent such Healthcare Services are required to be provided by a group health plan pursuant to Health Care Reform and the related regulatory guidance.

Reasonable: the determination that fee(s) or services are reasonable made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; and industry standards and practices as they relate to similar scenarios.

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical

care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Health Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Health Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Health Plan.

Rescind or Rescission: to retroactively terminate coverage under the Health Plan.

Special Enrollee: a Covered Individual who enrolls under the Health Plan other than during the first 31-day period in which the individual is eligible to enroll under the Health Plan and during a Special Enrollment Period. A Late Enrollee is not a Special Enrollee.

Special Enrollment Period: the period of time during which a person may become a Covered Individual due to the occurrence of an event recognized by the Health Plan as triggering Special Enrollment Period.

Spouse: the Covered Employee's spouse who is recognized as a spouse under the Code.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994.

Usual and Customary (U&C) Rates: part of the definition of Covered Charge and, therefore, part of the basis upon which this Health Plan pays for Covered Services, taking into consideration the fee(s) which the Healthcare Provider most frequently charges the majority of patients for the service or supply, the cost to the Healthcare Provider for providing the services, the prevailing range of fees charged in the same "area" by Healthcare Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Healthcare Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be "usual and customary," fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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

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

Note: "Usual and Customary Rate" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Individual by a Healthcare Provider of services or supplies, such as a Physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary Rate is, for any procedure, service, or supply, and whether a specific procedure, service or supply.

Usual and Customary Rates may, at the Plan Administrator's discretion, alternatively be determined and established by the Health Plan using normative data Including Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period: the period of time between the date on which a person has satisfied the eligibility requirements under this Health Plan and that person's Enrollment Date.

WHCRA: the Women's Health and Cancer Rights Act of 1998.

ESTABLISHMENT OF THE HEALTH PLAN;
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY DESCRIPTION, adopted by Aitkin County, hereby establishes the Aitkin County Hybrid Health Plan (Plan), effective January 1, 2016.

Effective Date. The Health Plan document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

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

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

Date: _____

AITKIN COUNTY

By: _____

Name: _____

Title: _____

ADDENDUM 1: CLAIM AND APPEAL PROCEDURES

A.1 **Introduction.** All Claims must be submitted to this Health Plan and all Claims review must comply with the rules and procedures set forth in this Health Plan. All Claims and appeals will be adjudicated in a manner so that the independence and impartiality of the persons involved in making the determination are ensured. Decisions regarding hiring, compensation, termination, and similar matters with respect to any individual involved in the determination (e.g., a Claims adjudicator or medical expert) shall not be based upon the likelihood that the individual will support a denial of benefits.

> **Note:** Information regarding "Making a Claim" appears in the *Summary Article* of this document. That description is to be read together with this Article.

A.2 **Types of Claims**

(a) This Health Plan recognizes two (2) categories of Benefits, each with its own requirements for making a Claim:

(1) Preventive Care Benefits; and

(2) Insurance Coverage Benefit.

(b) Each category of Claim has its own set of Claim and appeal requirements. The primary difference between the categories of Claims is the documentation necessary to establish a Claim.

> **Remember**: The Benefit under the Insurance Coverage Benefit portion of this Plan is the premium, not the coverage items provided through the policy.

A.3 **Filing a Claim.** Claims shall be made in accordance with Section 2.5 of this document.

A.4 **Initial Claim Determination.**

(a) **Time Frame for Decision**. The Health Plan must determine the Claim within a reasonable period of time not to exceed thirty (30) days of receipt of the Claim.

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

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

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

> **Tolling**: The period of time in which the Health Plan must determine a Claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

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

The notification will include a time frame of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, the Health Plan must decide the Claim within the extension described above. If the requested information is not provided within the time specified, the Claim may be decided without that information.

A.5 **Notification of Claim Decisions**

(a) **Health Plan Provided Notification of a Claim Determination.** Notification will be provided only if the decision is an Adverse Benefit Determination. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 42 USC § 300gg-19.

(b) **Content of Notification.** Notice of an Adverse Benefit Determination will be provided in written or electronic form. The notification shall at a minimum:

(1) Include information sufficient to identify the Claim involved, Including the date of service, the identity of the Healthcare Provider, and the Claim amount, and to inform the Claimant of the right to receive, upon request, the diagnosis and treatment codes (if any) and their corresponding meanings upon request;

(2) State the specific reason(s) for the determination, Including the denial code (if any) and its corresponding meaning, and describe the Health Plan's standard, if any, used to make the determination;

(3) Reference specific Health Plan provision(s) upon which the determination is based;

(4) Describe additional material or information necessary to complete the Claim and why such information is necessary;

(5) Describe the internal appeals and external review processes (if any) available under the Health Plan, Including how to initiate an appeal and the procedures and time limits applicable to an appeal;

(6) Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

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

(8) Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal Claims and appeals and external review processes (if any).

A.6 **Appeals Process.**

(a) **Access to Relevant Documents.** In order (1) to evaluate whether to request review of an Adverse Benefit Determination, and (2) if review is requested, to prepare for such review, the Claimant will have access to all relevant documents.

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

(b) **Full and Fair Review.** The Claimant will have the right to review the Claim file and to present evidence and testimony. The Claimant will be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Health Plan in connection with the Claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give the Claimant a reasonable opportunity to respond prior to that date. Before the Health Plan issues a final internal adverse benefit determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determined is required to give the Claimant a reasonable opportunity to respond prior to that date. The review of the adverse benefit determinations will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

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

(d) **Consultation with Independent Medical Expert.** In the case of a Claim denied on the grounds of a medical judgment, a Healthcare Provider with appropriate training and experience will be consulted. The Healthcare Provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

A.7 **Filing an Appeal.** If there is an Adverse Benefit Determination, the Claimant may request a review by the Plan Administrator by filing an appeal within a period of one-hundred eighty (180) days from the Adverse Benefit Determination. An appeal request must be in writing and submitted to the Plan Administrator.

A.8 **Timeframe for Appeal Decision.** This Health Plan will make a determination regarding an appeal within a reasonable period of time not to exceed sixty (60) days from the date the appeal was received.

> **Note:** Nothing precludes a Claimant from voluntarily agreeing to extend the timeframes specified below for this Health Plan to make a decision.

A.9 **Notification of Appeal Decision.** Written or electronic notification of this Health Plan's determination will be provided to the Claimant for all appeals. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 42 USC §300gg-19.

(a) **When Notice Will Be Provided.** Written or electronic notification of this Health Plan's determination will be provided to the Claimant for all appeals.

(b) **Content of Notification.**

(1) **Adverse Benefit Determination.** The notification will include at least the following:

(i) Include information sufficient to identify the Claim involved, Including the date of service, the identity of the health care provider, and the Claim amount, and to inform the Claimant of the right to receive, upon request, the diagnosis and treatment codes (if any) and their corresponding meanings upon request;

(ii) Contain a discussion of the determination, Including the specific reason(s) for the determination, the denial code (if any) and its corresponding meaning, and the Health Plan's standard, if any, used to make the determination;

(iii) Reference specific Health Plan provision(s) upon which the determination is based;

(iv) Describe the; external review process (if any) available under the Health Plan;

(v) Disclose any internal rules, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

(vi) A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;

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

(viii) Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the external review process (if any).

(2) **Not Adverse Benefit Decision.** Notice will be provided that informs the Claimant that the decision has been reversed, and the Claim has been approved.

A.10 **Deemed Exhaustion.** If the Health Plan fails to adhere to the requirements described in 42 USC §300gg-19(a)(1), the Claimant will be deemed to have exhausted the internal Claims and appeals process as provided in 42 USC § 300gg-19(a)(2)(B).

A.11 **Health Plan Interpretation.** This Health Plan will be administered in accordance with its terms. The Plan Administrator and/or a fiduciary acting as a fiduciary with respect to this Health Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Health Plan, to make factual findings, to construe the terms of this Health Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Health Plan, Including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Health Plan, Covered Individuals, Claimants, and all interested parties.

A.12 **Covered Individual's Right to Take Legal Action.** Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a Claim for Benefits. If a Claimant intends to initiate legal action, he or she must do so within two (2) years after receipt of a

notification of an Adverse Benefit Determination. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's Claim for Benefits was submitted to this Health Plan. Claimants may not bring legal action after the expiration of the two-year period.

Note: This is not the same as the period of time within which a Claim must be submitted to the Health Plan. *See Section 2.4 in the Summary Article of this document.*

A.13 **Questions Regarding Claims and Appeals Procedures.** If a Covered Individual has any questions regarding these procedures, the Covered Individual should contact the Plan Administrator at the number listed at the end of the *Introduction Article*.

A.14 **External Review Process.** Review by an accredited independent review organization ("IRO"), separate and apart from the Health Plan, may be available for an Adverse Benefit Determination in accordance with issued guidance. Claims eligible for federal external review are those involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (whether or not the rescission has any effect on any particular Benefit at the time).

(a) If a Covered Individual wants to have a Claim that was denied by the Health Plan reviewed externally, the Covered Individual (or someone on the Covered Individual's behalf) must file a request for an external review within four (4) months after the date of receipt of notice of an Adverse Benefit Determination. The request for an external review must be made in writing on the form made available by the Plan Administrator and submitted to the Plan Administrator.

In order to request an external review, the Covered Individual (or someone on the Covered Individual's behalf) must pay a filing fee of $25.00 at the time of the request for an external review. This filing fee will be refunded in the event the Adverse Benefit Decision is overturned upon external review. (The maximum aggregate filing fees are capped at $75.00 per Covered Individual per Coverage Year.)

(b) Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:

(1) the Covered Individual is (or was) covered under the Health Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Individual was covered under the Health Plan at the time the health care item or service was provided;

(2) the Adverse Benefit Determination is not based on the fact that the Covered Individual was not eligible for coverage under the Health Plan;

(3) the Covered Individual has exhausted the Health Plan's internal appeal process (unless exhaustion is not otherwise required); and

(4) the Covered Individual has provided all the information and forms required to process an external review.

The Covered Individual (or someone on the Covered Individual/s behalf) will be notified by the Plan Administrator of the results of the preliminary review of the request within one business day of the Claim Administrator's completion of the preliminary review. If the request is complete but not eligible for external review, the notice will state the reasons for the request not being eligible for external review and will provide other important information. If the request is

incomplete, the notice must describe the information, materials, etc. needed to complete the request. The Covered Individual (or someone on the Covered Individual/s behalf) will then be provided time to perfect the request; the longer of the initial four month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice.

(c) The parameters under which the IRO will operate Include the following:

The IRO will utilize legal experts where appropriate to make coverage determinations under the Health Plan. The IRO will notify the Covered Individual (or someone on the Covered Individual's behalf) in writing of the request's eligibility and acceptance for external review and that it has been assigned to conduct the external review. The Covered Individual (or someone on the Covered Individual's behalf) may submit additional information in writing to the IRO within 10 business days of the IRO's notification that is has been assigned the request for external review. The IRO must consider this additional information when conducting the external review.

The Plan Administrator will timely provide to the IRO documents and any information considered in making the Adverse Benefit Determination. The IRO will review all of the information and documents timely received. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

(1) the Covered Individual's medical records;

(2) the attending health care professional's recommendation;

(3) reports from appropriate health care professionals and other documents submitted by the Plan Administrator, the Covered Individual, or the Covered Individual's treating Healthcare Provider;

(4) the terms of the Covered Individual's summary plan description;

(5) evidence-based practice guidelines;

(6) any applicable clinical review criteria developed and used by the Plan Administrator; and

(7) the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

In making its decision, the IRO is not bound by the Health Plan's prior determination.

(d) The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, Including the rationale for its decision and any evidence-based standards that were relied on in making its decision. The notice of the final external review decision shall be provided to the Covered Individual (or someone on the Covered Individual's behalf) and the Health Plan. To the extent the final external review decisions reverses the Health Plan's decision (as was reflected in the Adverse Benefit Determination), the Health Plan shall follow the final external review decision of the IRO.

EE Health Care Spending OOP at given amount of claim EE responsibility

	Committed Cost = Premium	HealthSav Amt	$ -	$ 1,000	$ 2,000	$ 3,000	$ 4,000	$ 5,000	$ 6,000	$ 7,000	$ 8,000	$ 9,000	$ 10,000	$ 11,000	$ 12,000	$ 13,000
Single																
VEBA 100	1,752.00	(1,000.00)	752	1,752	2,602											
VEBA 80	78.00	(1,540.00)	(1,462)	(462)	538	1,218	1,418	1,618	1,818	2,018	2,218					
HDHP 5k/10k Ded	-	(1,540.00)	(1,540)	(540)	460	1,460	2,460	3,460								
Hybrid Low Ded	-	(1,000.00)	(1,000)	-	1,000											
Hybrid High Ded	-	(2,700.00)	(2,700)	(1,700)	(700)	300	1,300	2,300	3,300	3,850						
Single +1																
VEBA 100	14,574.00	(2,000.00)	12,574	13,574	14,574	15,574	16,274									
VEBA 80	9,822.00	(3,260.00)	6,562	7,562	8,562	9,562	10,562	11,562	11,922	12,122	12,322	12,522	12,722	12,922	13,122	
HDHP 5k/10k Ded	5,952.00	(3,260.00)	2,692	3,692	4,692	5,692	6,692	7,692	8,692	9,692	10,692	11,692	12,692			
Hybrid Low Ded	4,680.00	(2,000.00)	2,680	3,680	4,680	5,680	6,680									
Hybrid High Ded	1,200.00	(3,000.00)	(1,800)	(800)	200	1,200	2,200	3,200	4,200	5,200	6,200	7,200	8,200	9,200	10,200	11,200
Family																
VEBA 100	14,574.00	(2,000.00)	12,574	13,574	14,574	15,574	16,274									
VEBA 80	9,822.00	(3,260.00)	6,562	7,562	8,562	9,562	10,562	11,562	11,922	12,122	12,322	12,522	12,722	12,922	13,122	
HDHP 5k/10k Ded	5,952.00	(3,260.00)	2,692	3,692	4,692	5,692	6,692	7,692	8,692	9,692	10,692	11,692	12,692			
Hybrid Low Ded	7,080.00	(3,000.00)	4,080	5,080	6,080	7,080	8,080									
Hybrid High Ded	2,400.00	(4,000.00)	(1,600)	(600)	400	1,400	2,400	3,400	4,400	5,400	6,400	7,400	8,400	9,400	10,400	11,400

Distributed at Non-Union Staff Meeting 10-21-2015

	Employee Paid Premium (Monthly)	Employee Paid Premium (Annual)	HealthSav Contribution	Max OOP	Employee Worst Case	Total Premium	County Paid Premium	# of Plan Participants	Total Monthly Premium	Employer Paid Monthly Premium	Total Annual Premium	Employer Paid Annual Premium	Employer Annual Contribution to HealthSav	Plan Total Annual Employer Cost	
Existing Plans															
VEBA 100															
Single	146.00	1,752.00	1,000.00	1,850.00	2,602.00	821.00	675.00	43	35,303.00	29,025.00	423,636.00	348,300.00	43,000.00	391,300.00	9,100.00
Family	1,214.50	14,574.00	2,000.00	3,700.00	16,274.00	2,464.50	1,250.00	4	9,858.00	5,000.00	118,296.00	60,000.00	8,000.00	68,000.00	17,000.00
Veba 80															-
Single	6.50	78.00	1,540.00	3,500.00	2,038.00	706.50	700.00	63	44,509.50	44,100.00	534,114.00	529,200.00	97,020.00	626,220.00	9,940.00
Family	818.50	9,822.00	3,260.00	6,500.00	13,062.00	2,118.50	1,300.00	12	25,422.00	15,600.00	305,064.00	187,200.00	39,120.00	226,320.00	18,860.00
HDHP															-
Single	-	-	1,540.00	5,000.00	3,460.00	599.00	599.00	2	1,198.00	1,198.00	14,376.00	14,376.00	3,080.00	17,456.00	8,728.00
Family	496.00	5,952.00	3,260.00	10,000.00	12,692.00	1,796.00	1,300.00	19	34,124.00	24,700.00	409,488.00	296,400.00	61,940.00	358,340.00	18,860.00
Waiver	-	-	-			-	-	4	-	-	-	-	-	-	-
						Totals		147	150,415	119,623	1,804,974	1,435,476	252,160	1,687,636	-
Hybrid Plans															-
2000/4000 - 100%															-
Single	-	-	1,000.00	2,000.00	1,000.00	645.00	645.00	73	47,085.00	47,085.00	565,020.00	565,020.00	73,000.00	638,020.00	8,740.00
Single +1	390.00	4,680.00	2,000.00	4,000.00	6,680.00	1,290.00	900.00	25	32,250.00	22,500.00	387,000.00	270,000.00	50,000.00	320,000.00	12,800.00
Family	590.00	7,080.00	3,000.00	4,000.00	8,080.00	1,890.00	1,300.00	41	77,490.00	53,300.00	929,880.00	639,600.00	123,000.00	762,600.00	18,600.00
6550/13100 - 100%															-
Single	-	-	2,700.00	6,550.00	3,850.00	417.00	417.00	0	-	-	-	-	-	-	7,704.00
Single +1	100.00	1,200.00	3,000.00	13,100.00	11,300.00	834.00	734.00	0	-	-	-	-	-	-	11,808.00
Family	200.00	2,400.00	4,000.00	13,100.00	11,500.00	1,334.00	1,134.00	0	-	-	-	-	-	-	17,608.00
Waiver			3,350.00					8					26,800.00	26,800.00	3,350.00
						Totals		147	156,825	122,885	1,881,900	1,474,620	272,800	1,747,420	#VALUE!
Plan Comparison															-
						Compare		-	6,411	3,262	76,926	39,144	20,640	59,784	#VALUE!

Aitkin County Board of Commissioners
Board Meeting Attendance Record
Date: October 27, 2015

Name	Please check the boxes that apply.		
	Aitkin County Citizen	Aitkin County Employee	Company Representative – please list.
Bob Wagewood	✓		MYSELF
Adam Hoogenboom	✓		Aitkin Lakes Area Assn.
Terry Nett		—	PLZ
Steve Hughes		✓	Aitkin Co. SWCD
Lynn Pribbenow		✓	AIS INSPECTOR
Kyle Daun		✓	AIS Inspector
[illegible]	✓		
Mike Hagen	✓		Aitkin Grantee