

**Amendment to the
Summary Plan Description for
Dunn County Employee Medical Plan
HSA Medical Option**

**Amendment #2 to the
2013 Restated Summary Plan Description**

This Amendment is hereby made a part of the *Summary Plan Description (SPD)*, is effective January 1, 2015, and is as follows:

1. Subsection V.A. **Eligibility** is deleted in its entirety and replaced by the following:

A. Eligibility

You are eligible to enroll for coverage if *you* are:

1. Classified by the *Plan Sponsor* as a full-time or 80% employee regularly scheduled to work a minimum of 32 hours per week; or part-time employee working less than 32 hours a week.
2. A dependent of the employee. An employee must enroll for coverage in order to enroll his or her dependents. If both parents are covered as employees, a child may be covered as a dependent of either or both parents.

Eligible dependents include a *covered employee's*:

1. Lawful spouse of the opposite or same sex and does not include a common law spouse regardless if recognized under other state or country law. If a lawful spouse does not elect other available and affordable coverage, the contribution amount for that *covered employee's* family coverage under this *Plan* will be increased.
2. Children, from birth through age 25, including a:
 - a. Natural child;
 - b. Child who is legally adopted by or placed with *covered employee* for legal adoption from the earlier of the adoption date or the date of placement for adoption. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support;
 - c. Stepchild;
 - d. unmarried grandchildren who reside in *your* home in an on-going parent/child relationship that is intended to continue until their parent, *your covered dependent* reaches age 18, and are dependent on *you* for a majority of their financial support and are claimed as income tax dependents on *your* federal income tax return. After the parent of *your* grandchildren reaches age 18, the grandchildren must be placed in *your* legal custody;
 - e. Child for whom *covered employee* is the legal guardian appointed by a court of law;
 - f. Child covered under a valid Qualified Medical Child Support Order (QMCSO), which is enforceable against an eligible employee or a *covered employee*. An eligible employee or a *covered employee* may contact the *Plan Administrator* for free assistance in obtaining information regarding the procedures governing QMCSO determinations. The *Plan Administrator* is responsible for determining whether or not a medical child support order is a valid QMCSO.

If an eligible dependent child does not elect other available and affordable coverage, the contribution amount for that *covered employee's* family coverage under this *Plan* will be increased.

3. Children who are age 27 or more when discharged from the military and who are enrolled as students in regular full-time attendance at an accredited secondary or post-secondary educational institution as recognized by the U.S. Secretary of Education, which is an accredited high school, university, four-year college, community college, technical school, or vocational school. In order to qualify as an eligible dependent under this provision:
 - a. The student must carry the required number of credits per quarter/semester to qualify as a full-time student, as defined by the educational institution; and
 - b. The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.

Notwithstanding the provisions set forth in paragraph 3. above, a *covered dependent* shall be able to continue coverage from the date of a medically necessary leave of absence or change in student enrollment until the earliest of the date that is: 1) one year after the first day of such leave of absence or change in student enrollment; 2) the date on which such leave of absence or change in student enrollment is no longer medically necessary; or 3) the date on which coverage would otherwise end under the terms of the *Plan* (e.g., upon attaining the maximum age) if he/she:

- a. is a full-time student in a post-secondary accredited school and enrolled in the *Plan* on the day before a medically necessary leave of absence or change in student enrollment starts;
 - b. takes the leave of absence or makes a change to student enrollment as a result of a serious illness or injury that the attending physician certifies is medically necessary; and
 - c. loses full-time student status as a result of the medically necessary leave of absence or change in student enrollment.
4. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 30 calendar days after the dependent child reaches age 26. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* may request proof again each year. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this *Plan* and if he/she meets all of the following criteria:
 - a. Became disabled before age 26;
 - b. Was a *covered dependent* under the *Plan* prior to reaching age 26;
 - c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a *continuous* period of at least two years from the date initial proof is supplied to the *Plan*;
 - d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
 - e. Is unmarried.

If the dependent child is disabled and 26 years of age or older at the time of the *covered employee's* enrollment in this *Plan*, the *covered employee* may enroll the dependent child if within 30 calendar days after the *covered employee's* initial enrollment in this *Plan* the *covered employee* provides the *Plan* with proof that such dependent child meets all of the following requirements:

- a. Became disabled before age 26;
- b. Received health coverage through the *covered employee* within the 60-day period immediately preceding the *covered employee's* enrollment for coverage under this *Plan*;
- c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
- d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
- e. Is unmarried.

2. The New Enrollment paragraph of V.B. Enrollment and Effective Date is deleted in its entirety and replaced by the following:

New Enrollment. The eligible employee must make written application to enroll him/herself and any eligible dependents and pay any required *contribution*, within 30 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first day of the month immediately following a 30-day *waiting period*. Not subject to any pre-existing condition limitations.

3. Subsection VI. C. *Deductible, Out-of-Pocket Limit and Benefit Maximums* is deleted in its entirety and replaced with the following:

C. <i>Deductible, Out-of-Pocket Limit and Benefit Maximums</i>	NOTE: <i>Your coverage is either “covered employee only” or “family.” Therefore, only one of the following sections (“Covered employee only” or “Family”) applies to you. If you have questions about which section applies to you, contact TPA or your employer.</i>
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Covered Employee Only

Deductible: The *covered employee* must first satisfy the *deductible* amount by *incurring* charges equal to that amount for eligible services in a *calendar year* before the *Plan* will pay *benefits*. Copies of bills for eligible services used to satisfy the *deductible* must be submitted to the *Plan*. The *Plan* will not pay *benefits* for the *eligible charges* applied toward the *deductible*. Pre-certification penalties and any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the *deductible*. The *covered employee will not be required to satisfy the deductible before the Plan will pay benefits for the following: preventive health care services from participating providers.*

Out-of-Pocket Limit: After the *covered employee* has met the *out-of-pocket limit* per *calendar year* for *coinsurance* and *deductibles*, *Plan* covers the charges *incurred* for all other *eligible charges*. The *covered employee* pays any amounts greater than the *out-of-pocket limit* if any *benefit maximums* are exceeded. It is the *covered employee’s* responsibility to demonstrate to the *Plan* the *coinsurance* and *deductibles* in excess of this amount have been paid in any *calendar year*, and to pay any amounts greater than the *out-of-pocket limits* if any *benefit maximums* are exceeded. Expenses paid for any amount in excess of the *usual and customary amount* will not apply towards satisfaction of the *out-of-pocket limit*. The cost differential between a brand-name drug and a generic drug does not apply to the *out-of-pocket limit* if you request a brand-name drug when an equivalent generic drug is available.

Annual Benefit Maximum: The annual *benefit maximum* is the cumulative amount per *covered person* for all *eligible charges* while covered under any and all plans, or options providing health care *benefits* offered by the Employer.

<i>Covered Employee Only</i>	<i>Participating Providers</i>	<i>Non-Participating Providers</i>
<i>Deductible</i>	The <i>deductible</i> for services received from <i>participating providers</i> and <i>non-participating providers</i> is combined.	
	\$1,500 per <i>covered person</i> per <i>calendar year</i> .	\$2,000 per <i>covered person</i> per <i>calendar year</i> .
<i>Out-of-Pocket Limit</i>	The <i>out-of-pocket limit</i> for services received from <i>participating providers</i> and <i>non-participating providers</i> is combined.	

	\$1,500 per covered person per calendar year.	\$2,000 per covered person per calendar year.
Benefit Maximums		
Annual Benefit Maximum	Unlimited.	
Lifetime Benefit Maximum	Unlimited.	

Family (Covered Employee and Covered Dependents)

Family Deductible: The family must first satisfy the family deductible amount by incurring charges equal to that amount for eligible services in a calendar year before the Plan will pay benefits. Copies of bills for eligible services used to satisfy the family deductible must be submitted to the Plan. The Plan will not pay benefits for the eligible charges applied toward the family deductible. Pre-certification penalties and any amount in excess of the usual and customary amount will not apply towards satisfaction of the family deductible. Covered persons of the family will not be required to satisfy the family deductible before the Plan will pay benefits for the following: preventive health care services from participating providers.

Family Out-of-Pocket Limit: After the family has met the family out-of-pocket limit per calendar year for coinsurance and family deductibles, the Plan covers the charges incurred for all other eligible charges. The family must pay any amounts greater than the family out-of-pocket limit if any benefit maximums are exceeded. It is the family's responsibility to demonstrate to the Plan the coinsurance and family deductibles in excess of this amount have been paid in any calendar year, and to pay any amounts greater than the family out-of-pocket limit if any benefit maximums are exceeded. Expenses paid for any amount in excess of the usual and customary amount will not apply towards satisfaction of the family out-of-pocket limit. The cost differential between a brand-name drug and a generic drug does not apply to the out-of-pocket limit if you request a brand-name drug when an equivalent generic drug is available.

Annual Benefit Maximum: The annual benefit maximum is the cumulative amount per covered person for all eligible charges while covered under any and all plans, or options providing health care benefits offered by the Employer.

Family (Covered Employee and Covered Dependents)	Participating Providers	Non-Participating Providers
Family Deductible	The deductible for services received from participating providers and non-participating providers is combined.	
	\$3,000 per family per calendar year.	\$4,000 per family per calendar year.
Family Out-of-Pocket Limit	The out-of-pocket limit for services received from participating providers and non-participating providers is combined.	
	\$3,000 per family per calendar year.	\$4,000 per family per calendar year.
Benefit Maximums		
Annual Benefit Maximum	Unlimited.	
Lifetime Benefit Maximum	Unlimited.	

4. The exclusion for “*Prescription drugs* and over-the-counter drugs for smoking cessation” in the list of exclusions in subsection **VI. P. Prescription Drug Services** and the corresponding list in Section **VII. Exclusions** is deleted and replaced with the following:

- *Prescription drugs* and over-the-counter drugs for tobacco cessation, except as covered as a *preventive health care service*.

5. Subsection **VI. R. Preventive Health Care Services** is amended by the addition of the following to the schedule of *benefits* of preventive services required by the *Affordable Care Act*:

- | | | |
|---|--|--|
| • Designated tobacco cessation intervention programs. | 100% of <i>eligible charges</i> .
<i>Deductible</i> does not apply. | 100% of <i>eligible charges</i>
after the <i>deductible</i> . |
|---|--|--|

6. The provision titled “Special Rule for Pre-Existing Conditions” in Section **X. COBRA Continuation Coverage** is deleted in its entirety.

7. Paragraph 4. of subsection **XIII. C. Order of Benefit Determination Rules** is deleted and replaced with the following:

4. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
- The plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan.
 - The continuation coverage is the secondary plan.
 - If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

8. Subsection **XIII. D. The Effect on the Benefits of This Plan** is deleted and replaced with the following:

D. THE EFFECT ON THE BENEFITS OF THIS PLAN: When this *Plan* is secondary, it may reduce its *benefits*, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses. The reduction in this *Plan’s benefits* is equal to the difference between:

- the *benefit* payments that this *Plan* would have paid had it been the primary plan; and
- the *benefit* payments that this *Plan* actually paid or provided.

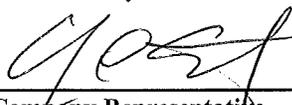
When the *benefits* of this *Plan* are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as the *deductible* of this *Plan*.

This Amendment does not change, alter, or amend any of the other provisions or limitations of the SPD.

This Amendment will be printed following receipt of the following signatures. Agreed to and accepted by:

Plan Sponsor
Dunn County

Third Party Administrator
PreferredOne Administrative Services, Inc.



Company Representative
County Manager

Title
Eugene C Smith

(Please print name of Company Representative)
3-1-15

Date

Company Representative

Title

(Please print name of Company Representative)

Date

Important Note For Employers/Plan Sponsors: *PreferredOne* recommends that each employer/*plan sponsor* consult with their tax and/or legal advisor to review the *Plan's* current provisions (including, but not limited to, the eligibility, enrollment, termination of coverage, and employee contribution/premium sharing provisions), employer's overall employee/workforce demographics, and all other relevant facts and circumstances to determine: (a) whether employer is an "applicable large employer" within the meaning of Section 4980H of the Internal Revenue Code and the guidance issued thereunder ("Section 4980H"); (b) the applicable date of Section 4980H; and (c) whether employer has any risk of penalties under Section 4980H (i.e., the employer shared responsibility penalties aka "pay or play penalties"). Employer is solely responsible for making such determinations and ensuring the Plan Document and each *Summary Plan Description (SPD)*, including, but not limited to, the eligibility, enrollment, and termination of coverage provisions thereof, are drafted in a manner consistent with employer's strategy (if any) for mitigating such penalties. If employer is using the look back measurement method under Section 4980H (the "look back method"), employer is solely responsible for ensuring the Plan Document and each SPD contain the provisions needed to enable employer to use the look back method. Employer is also solely responsible for drafting and adopting a separate document containing employer's policies and procedures implementing the look back method and for administering such policies and procedures. Employer shall make such policies and procedures available to *PreferredOne* and employer's excess risk insurer upon request. *PreferredOne* has no responsibility for making any determinations or taking any actions referenced in this note and shall have no liability with respect to any penalties assessed against employer under Section 4980H.