Summary Plan Description

Delta Dental PPO

for

ASPIRUS, INC

ASPIRUS WAUSAU HOSPITAL
ASPIRUS INC.
ASPIRUS EXTENDED SERVICES, INC.
ASPIRUS MEDICAL GROUP, INC.
ASPIRUS ONTONAGON HOSPITAL
ASPIRUS VNA HOME HEALTH INC.
ASPIRUS IRONWOOD HOSPITAL
ASPIRUS IRON RIVER HOSPITAL
ASPIRUS RIVERVIEW HOSPITAL
ASPIRUS DIVINE SAVIOR HEALTHCARE
ASPIRUS STEVENS POINT HOSPITAL
ASPIRUS STANLEY HOSPITAL
ASPIRUS MERRILL HOSPITAL
ASPIRUS RHINELANDER TOMAHAWK
ASPIRUS EAGLE RIVER HOSPITAL
HOWARD YOUNG HC MEDICAL CENTER
ASPIRUS MEDFORD HOSPITAL & CLINIC
ASPIRUS KEWEENAW HOSPITAL
ASPIRUS LANGLADE HOSPITAL

50423

Table of Contents

I. Plan Description Information

II. Description of Benefits

III. Claims Procedures

IV. Statement of ERISA Rights

V. HIPAA Medical Privacy Provision

I. Plan Description Information

1. Plan Name ("Plan"): Aspirus Inc. Group Dental Plan

2. Plan Sponsor:
   Aspirus Inc.
   2200 Westwood Dr.
   Wausau, WI 54401

3. Plan Administrator and Named Fiduciary:

   Aspirus Inc.
   2200 Westwood Dr.
   Wausau, WI 54401
   715-843-1224

4. Plan Sponsor's Employer Identification Number (EIN): 39-1138241.
   The Plan number assigned for government reporting purposes is 555.

5. The Plan provides dental benefits for participating employees, certain retirees [if applicable], and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.

6. Plan benefits described in this booklet are effective January 1, 2023.

7. The Plan year is January – December.
   The Fiscal year is July – June.

8. Agent for service of legal process:

   Aspirus Inc.
   2200 Westwood Dr.
   Wausau, WI 54401

9. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan has full and final authority on all claim denial disputes. The Claims Administrator is:

   Delta Dental of Wisconsin
   P.O. Box 828
   Stevens Point, WI 54481
   Telephone: 715-344-6087
   Toll Free: 800-236-3712

10. The Plan's contributions are shared by the employer and employee. The employer contribution is subject to change each year, depending upon claims experience and Plan expenses.

11. Each employee participating in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are this booklet. This booklet will be provided by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to covered persons as required by applicable law.

13. Upon termination of the Plan, the rights of the covered persons to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the covered persons, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

II. Description of Benefits

Delta Dental has been selected by your employer to provide your dental benefits administration. All of us at Delta Dental are pleased to provide this service to you and any dependents you have enrolled. As a participant of this dental Plan, you are free to see any provider you choose on a treatment-by-treatment basis whether or not the provider is included in our Delta Dental PPO Provider Directory. It is important to remember, however, that your out-of-pocket costs may be lower when you see a Delta Dental PPO provider.

Delta Dental PPO Providers

Delta Dental PPO Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Providers Outside the Delta Dental PPO Network

Delta Dental Premier Providers

Delta Dental Premier Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). However, you are still responsible for deductibles, copayments, coinsurance, and fees for services that are not benefits under this dental Plan.

Noncontracted Providers

If your provider has not signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the provider. You will then reimburse your provider through his or her usual billing procedure. You will be responsible for any amount in excess of the Maximum Plan Allowance, as well as any deductible, copayment, coinsurance, and fees for services that are not benefits under this dental Plan.

Please note that if the fee charged by a noncontracted provider is not allowed in full, Delta Dental is not implying that the provider is overcharging. Dental fees vary and are based on each provider's overhead, skill, and experience. Therefore, not every provider will have fees that fall within the MPA.

For information on Delta Dental PPO or Delta Dental Premier Providers, visit Delta Dental's website at www.deltadentalwi.com or call 800-236-3712.

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit.

Filing Claims

To file a claim with Delta Dental, simply present your employee identification card to the receptionist at the dental office, or give your member number. Claims must be filed on forms acceptable to Delta Dental.

Predetermination of Benefits

After an evaluation, your provider may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or implants, ask your provider to send the treatment plan with x-rays to Delta Dental. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to you and your provider.

The Predetermination of Benefits form is valid for 1 year from the date issued.

Predeterminations are not required, but Delta Dental encourages you to use this service. Should you have any questions about a predetermination, just call us at 800-236-3712.

Before you schedule dental appointments, you should discuss with your provider the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Optional Procedures

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive dental procedure that is adequate to restore the tooth or dental arch to contour and function, but only if the more expensive dental procedure is a benefit under your dental Plan. You will be responsible for the remainder of the provider's fee if a more expensive dental procedure is selected or the entire fee if the more expensive dental procedure is not a benefit. The coinsurance and deductible will apply regardless of which dental procedure is selected.

Clerical or Administrative Error

If a clerical error or other administrative mistake occurs, that error will not deprive you of coverage under your dental Plan that you would otherwise have had. A clerical error or other administrative mistake also will not create coverage for you under your Plan if coverage does not otherwise exist.

Summary of Benefits

Group Number: 50423

Effective Date of Program: January 1, 2023

Dependents to Age: 26
Dependents are covered through the end of the month the age limit is reached.

Deductibles:

Per Person, per Benefit Accumulation Period: $50.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period: $500.00 **

Orthodontic Maximum Benefit per Lifetime: $0.00

** There is no annual Benefit maximum applied to Diagnostic and Preventive Procedures.

The benefits of your dental Plan will depend on the provider you choose. Delta Dental PPO Providers agree to accept payment based on a reduced schedule, which means your out-of-pocket costs will be less. The coverage percentage listed in the Delta Dental PPO column applies.

Delta Dental Premier Providers agree to not charge you any amount that exceeds the MPA. The coverage percentage listed in the All Other Providers column applies when treatment is provided by Delta Dental Premier Providers or by providers who have not signed any agreements with Delta Dental.

Benefits:	**Delta Dental PPO**	**All Other Providers**
Diagnostic and Preventive Procedures	**100%**	**100%**
Basic Restorative Procedures	**80%***	**80%***
Major Restorative Procedures	**0%**	**0%**
Orthodontic Procedures	**0%**	**0%**

** Deductible applies.*

After you have satisfied the deductible requirements as stated, the program provides payment at the indicated percentage of fees, up to the maximum stated for each eligible person in each Benefit Accumulation Period. A Benefit Accumulation Period is a 12-month period of time over which deductibles (if any) and maximums apply. The Benefit Accumulation Period is January 1st through December 31st.

Covered Procedures

Please see the Summary of Benefits page for the coverage percent for each category.

Covered services are subject to the limitations described within each coverage category below and the Exclusions outlined later.

Diagnostic and Preventive Procedures

1. Evaluations twice per calendar year.
2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals. Full mouth x-rays may be either individual images or panoramic image.
3. Bitewing x-rays once per calendar year, limited to a set of 4 images.
4. Prophylaxis (teeth cleaning) twice per calendar year.
5. Topical fluoride applications once per calendar year, for dependent children up to age 18.
6. Space maintainers for retaining space when a posterior primary tooth is prematurely lost.
7. Pathologic exams; bacteriologic studies; biopsy; consultations and office visits.
8. TMJ x-rays.
9. Minor treatment to control harmful habits.
10. Topical application of sealants for dependents to age 19. Application is limited to the occlusal surface of bicuspids and molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.

Basic Restorative Procedures

1. Emergency treatment to relieve pain.
2. *a*. amalgam (silver) restorations;
   b. composite (tooth colored) restorations;
   c. Prefabricated crowns — 1 per tooth at 3-year intervals.

Basic and Major Restorative Procedures – Listed below are not covered.

1. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
2. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
3. Endodontics (root canal treatment).
4. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical benefit is limited to once per quadrant at 24-month intervals; surgical benefit is limited to once per quadrant at 36-month intervals. Periodontal maintenance — either periodontal maintenance or adult prophylaxis twice per calendar year.
5. Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a benefit once in any 36 month period.
6. Crowns, inlays or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure as a benefit under this dental Plan.

7. Prosthetics, including fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing prosthetic will be provided only after a five-year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure under this dental Plan.
   Fixed bridges, implants, or partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed bridge, or implant and implant-related procedures may be a benefit if no more than two teeth are missing in the dental arch in which the bridge is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch.
   a. porcelain veneers on crowns or pontics on the six front teeth, bicuspids and upper first molars.

   Coverage for initial replacement of teeth is not limited to those lost while you are covered under this dental Plan.

Orthodontic Procedures – Listed below are not covered

Orthodontic services include orthodontic appliances, treatment, and related services for orthodontic purposes, including evaluation, x-rays, extractions, photographs, study models, etc., for persons eligible as stated on the Summary of Benefits page.

Your coverage includes orthodontic treatment in progress. Delta Dental's payment for orthodontic treatment in progress extends only to the unearned portion of the treatment. Delta Dental will determine the unearned amount eligible for coverage.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental will pay only for services and supplies actually received. No benefits are available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: One-fourth of the total case fee is considered the initial or down payment fee, subject to the coverage percentage, any applicable deductible and the orthodontic maximum benefit stated herein. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percent stated on the Summary of Benefits page.

Exclusions

This dental Plan does not provide coverage for the following:

1. Dental procedures, services treatment or supplies provided or commenced prior to the effective date of your coverage under this dental Plan or after the termination date of coverage, unless otherwise indicated;
2. Dental procedures, services treatment or supplies to treat injuries or conditions compensable under worker's compensation or employer's liability laws;
3. Prescription drugs, premedications or relative analgesia;
4. Preventive control programs;
5. Charges for failure to keep a schedule appointment;
6. Charges for completion of forms;
7. Charges for consultation;
8. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a Provider for treatment in any such facility;
9. Charges for treatment of, or services related to, temporomandibular joint dysfunction;
10. Dental procedures, services, treatment and supplies that are determined to be partially or wholly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Crowns placed on covered dependents under age 12, other than prefabricated crowns;
12. Prosthetics placed on covered dependents under age 16;
13. Appliances, restorations, or procedures for: (a) increasing vertical dimension; (b) restoring occlusion; (c) correcting harmful habits; (d) replacing tooth structure lost by attrition, erosion, abrasion, or abfraction; (e) correcting congenital or developmental malformations except in newly born children; (f) replacement, provisional and temporary services; (g) implantology techniques; (h) splints, unless necessary as a result of accidental injury;
14. Dental procedures, services, treatment or supplies provided by an individual other than a Provider;
15. Dental procedures, services, treatment or supplies to treat injuries or diseases caused by riots or any form of civil disobedience;
16. Dental procedures, services, treatment or supplies to treat injuries sustained while committing a felony or engaging in an illegal occupation;
17. Dental procedures, services, treatment or supplies to treat injuries intentionally inflicted;
18. Replacement of lost or stolen dentures or charges for duplicate dentures;
19. Dental procedures, services, treatment or supplies in cases for which, in the professional judgment of the attending Provider, a satisfactory result cannot be obtained;
20. Local anesthetic is covered as a part of a dental procedure, service or treatment. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures);
21. If orthodontic procedures are included as benefits under this dental Plan, the repair and replacement of orthodontic appliances is not covered;
22. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided;
23. Dental procedures, services, treatment or supplies excluded as provided in the Summary of Benefits;
24. Dental procedures, services, treatment or supplies not specifically covered under this dental Plan or excluded by Delta Dental rules and regulations, including Delta Dental processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

Coordination of Benefits

Applicability

This Coordination of Benefits (COB) provision applies to This Plan when you or a covered dependent has health care coverage under more than one Plan. “Plan” and “This Plan” as used in this Coordination of Benefits provision are defined below.

If this COB provision applies, the Order of Benefit Determination Rules shall be applied first. The rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. shall not be reduced when under the Order of Benefit Determination Rules, This Plan determines its benefits before another plan, but
2. may be reduced when, under the Order of Benefit Determination Rules, another plan determines its benefits first. This reduction is described in the section, Effect on the benefits of This Plan.

Definitions

The following definitions apply to this Coordination of Benefits provision:

“Allowable Expense” means an item of dental expense that is covered at least in part by one or more of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the cash value of each procedure provided shall be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a calendar year during which Allowable Expenses are compared with total benefits payable under the policy (without applying COB). It does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

“Plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid, Title XIX, grants to states for medical assistance programs, or the United States Social Security Plan whose benefits, by law, are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under 1. or 2. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

“Primary Plan/Secondary Plan”: The Order of Benefit Determination Rules state whether This Plan is a primary Plan or secondary Plan as to another Plan covering the person. When This Plan is a secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When Delta Dental is the secondary Plan, Delta Dental may reduce the benefits under its Plan only when the sum of the following exceeds the total allowable expense in a Claim Determination Period.

1. The benefits the secondary Plan would pay for allowable expenses in the absence of COB; plus
2. The benefits that would be payable under other applicable Plans for allowable expenses in the absence of COB, whether or not claim is made.

The amount by which the secondary Plan's benefits are reduced shall be used by the secondary Plan to pay allowable expenses not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

When there are more than two Plans covering the person, This Plan may be a primary Plan as to one or more other Plans and may be a secondary Plan as to a different Plan or Plans.

"This Plan" means this dental Plan that provides benefits for dental care expenses.

Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and other Plan, This Plan is a secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of This Plan; and
2. both those rules and This Plan's rules described in subparagraph 2.b. require that This Plan's benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules, which applies.

1. Nondependent/Dependent. The benefits of the Plan that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.

2. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 3.c. below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but
   b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer will be determined before those of the Plan that covered the other parent.

   However, if the other Plan does not have the rule described in *a.* but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's dental care expenses or if the court decree states that both parents shall be responsible for the dental care needs of the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents' Plan have actual knowledge of those terms, benefits for the dependent child shall be determined according to paragraph 2*b*;

however, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of a child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule 4. is ignored.

5. Continuation Coverage.
   a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:
      1) First, the benefits of a Plan covering the employee, member, or subscriber or dependent of an employee, member, or subscriber.
      2) Second, the benefits under the continuation coverage.
   b. If the other Plan does not have the rule described in subparagraph a., and if as a result, the Plans do not agree on the order of benefits, this paragraph 5. is ignored.

6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

   If a covered person is entitled to coverage under a group health care Plan which primarily covers services or expenses other than dental care, and if the covered person first became eligible under the medical and dental Plans on the same date, this dental Plan shall be the secondary payer for those services covered by both Plans.

Effects on the Benefits of This Plan

When This Provision Applies. This "Effects on the Benefits of This Plan" provision applies when, in accordance with the "Order of Benefit Determination Rules" provision above, This Plan is a secondary Plan as to one or more other Plans. In that event, benefits of This Plan may be reduced under this paragraph so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses. Such other Plan or Plans are referred to as "the other Plans" in the "Reduction in This Plan's Benefits" provision below.

Reduction in This Plan's Benefits. The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable for the total allowable expenses in a Claim Determination Period under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

When a Plan provides benefits in the form of services, the cash value of each service rendered will be considered both an expense incurred and a benefit payable.
When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

No rule in other Plan. If the other Plan does not have rules coordinating benefits with those of This Plan, the benefits of the other Plan are determined first.

Right to Receive and Release Needed Information

Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without your consent, but only as needed to apply these COB rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under This Plan must give Delta Dental any facts it needs to process the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Delta Dental will not have to pay that amount again. The term “payment made” means the cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess, at its option, from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The “amount of payments made” includes the cash value of any benefits provided in the form of services.

Eligibility

Covered Employee

You are covered by this dental Plan while you are an eligible employee of the group.

You may also be covered by this dental Plan if you no longer meet the eligibility conditions but have elected to continue coverage as described in the **Federal Continuance Provision (COBRA)** section of this Description of Benefits.

Covered Dependents

If you are enrolled for family coverage, the following persons are covered under this dental Plan as your dependents:

1. Your lawful spouse;
2. Your Domestic Partner (Not eligible for Aspirus – Langlade employees);
3. You or your Domestic Partner's children, including step and adopted children and children placed for adoption with you, who are less than 26 years of age.
4. Children of your Domestic Partner provided that the Domestic Partner is enrolled as a covered dependent on the plan.
5. You or your Domestic Partner's children, including step and adopted children and children placed for adoption with you, who satisfy all of the following:
   (a) The child is a full-time student, regardless of age; and
   (b) The child was under 26 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; and
   (c) The child re-enrolled as a full-time student within 12 months of returning from active duty.
6. You or your Domestic Partner's dependent children age 26 and over who are incapable of supporting themselves because of physical or mental incapacity that began prior to their 26th birthday or the date you became eligible for this dental plan.

Dependents in military service are not covered by this dental Plan.

Dependents no longer meeting these requirements because of divorce, separation or termination of Domestic Partnership from an eligible employee, or the end of a child's dependency status may elect to continue coverage. Please see the Federal Continuation Provision (COBRA) section of this Description of Benefits.

Plan Sponsor reserves the right to require that an enrollee or Covered Employee seeking coverage of a dependent provide written documentation, initially and annually thereafter, that the dependent child satisfies the requirements for coverage under this plan.

Plan Sponsor is responsible for making the determination as to whether a person qualifies for coverage as a Domestic Partner and will advise Delta Dental when it has made such a determination for an Eligible Employee.

Domestic Partners (Not eligible for Aspirus – Langlade employees)

Your Domestic Partner means an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, is jointly responsible for the other's welfare and financial obligations, is at least 18 years of age and have the capacity to enter into a contract, is not related by blood or marriage closer than permitted under the marriage laws of the State of Wisconsin, maintains the same residence and is not legally married or legally separated from anyone else. A Domestic Partner certification is required to be completed and filed with the Plan at the time enrollment of the Domestic Partner is requested.

For Your Domestic Partner to qualify as a Dependent, You and Your partner must complete an affidavit declaring that You and Your partner:

- Are engaged in an exclusive and committed relationship and intend to remain together indefinitely;

- Have entered into the domestic partnership voluntarily, willingly and without reservations;
- Have been living together as a couple for at least 12 months at the same residence and
- intend to continue to do so indefinitely;
- Are not legally married to anyone else and do not have other Domestic Partners;
- Are jointly responsible to each other's common welfare and shared financial obligations which can be demonstrated by the existence of at least two (2) of the following:

    - ❖ Domestic Partnership Agreement Certificate from City, County, or state of residence;
    - ❖ Joint mortgage or lease;
    - ❖ Designation of Domestic Partner as beneficiary for Employee's life insurance;
    - ❖ Designation of Domestic Partner as beneficiary for Employee's retirement Plan;
    - ❖ Designation of Domestic Partner as primary beneficiary for Employee's will or of Employee in Domestic Partner's will;
    - ❖ Durable property and health care powers of attorney;
    - ❖ Joint ownership of motor vehicle;
    - ❖ Joint checking account;
    - ❖ Certificate of Marriage that is recognized by any state or foreign country.

A Dependent Child until the Child reaches his or her 26th birthday. The term "Child" includes the following Dependents:

- A natural biological Child;
- A stepchild;
- A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
- A Child under Your (or Your spouse's or Domestic Partner's) Legal Guardianship as ordered by a court;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
- A Child of a Domestic Partner.

Adding a Domestic Partner:

If a subscriber wishes to add a Domestic Partner and his/her Domestic Partner’s eligible dependent children, if any, the subscriber must apply for coverage within 31 days of the date the subscriber registers such partner as a Domestic Partner with us. To register a Domestic Partner, we must receive a completed “Declaration of Domestic Partnership Affidavit” on a form approved by us. The effective date of the Domestic Partner’s and the Domestic Partner’s children’s, if applicable, coverage will be the first of the month following our receipt of the completed enrollment form. If we receive an enrollment form after that 31-day period ends, the Domestic Partner and the Domestic Partner’s eligible children, if any, may not be added until the next annual open enrollment period.

Effective Dates of Coverage

You are covered by this dental Plan beginning on the first day this dental Plan becomes effective or as determined by the group.

Your eligible dependents are covered beginning on the first day you become covered under the dental Plan.

Changes in Coverage

You may change your enrollment in this dental Plan if there is a qualifying event. The enrollment change will be effective as determined by the group. Notification of the enrollment change must be received by us within 31 days of the change.

You may change your enrollment without a qualifying event during the open enrollment, if an open enrollment period is offered by your group.

Notices

Notice to the group or Delta Dental will be considered sufficient if mailed to their regular office address. Notices to you, as a subscriber, will be considered sufficient if mailed to your last known address or the last known address of the group. It is the responsibility of the group to notify you regarding changes or termination of your coverage.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the day you or your dependents are no longer eligible or the day this dental Plan is terminated.

If you or your dependents lose eligibility under the dental Plan, you or your dependents may elect to continue coverage as described in the **Federal Continuation Provision (COBRA)** section of this Description of Benefits.

All coverage ends on the day coverage terminates. Procedures must be fully completed prior to termination of the coverage to be considered for benefit.

All benefits cease on the day coverage terminates. A dental procedure is incurred on the date it is completed. Dental procedures are considered for benefits if they are incurred during the contract term and a claim is filed within one year after the date it is incurred.

Uniformed Services Employment and Reemployment Rights Act

If you are going into or returning from military service, you may have special rights to coverage under this dental Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended coverage. If you may be affected by this law, ask your Plan Administrator for further details.

Upon returning to active status from military leave of 30 or more days the employee may enroll in the Plan with no waiting period.

Coverage Pursuant to Qualified Medical Child Support Order

The Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support orders (QMCSOs). The Plan Administrator will develop written procedures to determine whether a medical child support order is a QMCSO and to administer the provision of Plan benefits pursuant to QMCSOs. Subscribers and dependents may obtain, without charge, a copy of the QMCSO procedures from the Plan Administrator.

Upon receiving a medical support order, the Plan Administrator will promptly notify the affected dependent and each alternate recipient that the order has been received and describe the Plan's procedures for determining whether the medical child support order is a QMCSO. Within a reasonable period after receiving a medical child support order, the Plan Administrator will determine whether such an order is a QMCSO and will notify the subscriber and each alternate recipient of such determination.

Federal Continuation Provisions (COBRA)

Continued Coverage

If your employer employs more than 20 employees, Title X of the Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA) applies. Under COBRA, if you and your covered dependents were covered under this Plan the day before a Qualifying Event, you are "Qualified Beneficiaries" and may elect continuation of dental coverage under this Plan. COBRA defines a Qualifying Event as:

For the Subscriber:

1. The termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. The reduction of hours to fewer than the minimum required for coverage under this dental Plan.

For Covered Dependents:

1. If the covered dependent is the subscriber's spouse or domestic partner*:
   *Note: Domestic Partner eligibility for COBRA requires the subscriber to enroll in COBRA.
   a. Death of subscriber; or
   b. Termination of subscriber's employment, except for reasons of gross misconduct; or
   c. Reduction of subscriber's hours to fewer than the minimum required for coverage under this dental Plan; or
   d. Divorce or legal separation from subscriber; or
   e. Subscriber's Medicare entitlement.

2. If the covered dependent is the subscriber's or domestic partner's child*:
   *Note: Domestic Partner child eligibility for COBRA requires the subscriber and subscriber's domestic partner to enroll in COBRA.
   a. Child ceases to be a dependent; or
   b. Death of subscriber; or
   c. Termination of subscriber's employment, except for reasons of gross misconduct; or
   d. Reduction in subscriber's hours to less than the minimum required for coverage under this dental Plan; or
   e. Subscriber's Medicare entitlement; or
   f. Parents become divorced or legally separated.

The group must provide notice to a Qualified Beneficiary of the right to elect COBRA continuation coverage.

A covered dependent whose coverage is terminated due to divorce, legal separation, termination of domestic partnership or cessation of eligibility for dependent coverage must provide the group with notice of such event within 60 days of its occurrence.

The Qualified Beneficiary must make an election of continuation coverage within 60 days beginning on the later of the date of the Qualifying Event or the date the Qualified Beneficiary receives notice of COBRA election rights. The COBRA election by a subscriber or a subscriber's covered spouse is deemed an election by all others who would lose coverage as a result of the same-Qualifying Event unless otherwise specified in the election or the covered beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

1. Eighteen months for all Qualified Beneficiaries after the subscriber's employment termination or reduction in hours.
2. Twenty-nine months after the Qualifying Event for a subscriber or covered dependent who is determined to be disabled under the Social Security Act prior to the 60th day of COBRA coverage and the disability continues during the rest of the 18-month COBRA coverage period. The disabled Qualified Beneficiary must notify the Plan of the disability determination within the first 18 months of COBRA coverage. Coverage will also be continued for any non-disabled family member who is a Qualified Beneficiary with respect to the same Qualifying Event.
3. For Qualified Beneficiaries other than the subscriber who experience a second Qualifying Event, 36 months after the date of the initial Qualifying Event.
4. The date on which the Qualified Beneficiary receiving continuation coverage fails to make a timely payment of premium. Delta Dental will not reinstate COBRA continuation coverage once terminated for nonpayment of premium.
5. The date on which the group ceases to offer this dental Plan to any of its employees or members.
6. The date on which coverage begins under another group dental plan; however, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.
7. The date the Qualified Beneficiary becomes entitled to Medicare benefits.

The first premium must be paid to the group within 45 days of the election of COBRA continuation coverage and payment must include all premiums from the effective date of COBRA continuation coverage. Future premium payments must be paid by the first day of each month.

In accordance with ERISA Section 602(3), premium for a Qualified Beneficiary who becomes disabled during the first 60 days of COBRA coverage will be 150% of the single, family, or other applicable rate for the coverage during months 19 through 29 of COBRA coverage. The premium for all other COBRA continuation coverage will not exceed 102% of the rate in effect for the group during months one through 18.

If you have any questions about continued dental coverage, the human resources department at your company can help you.

Rights of Recovery (Subrogation)

If expenses are paid on your behalf under this Plan, the Plan is entitled to all rights of recovery you may have against any other person for those expenses to the extent of the Plan's payment. The Plan can subrogate only if you are fully compensated for all damages, taking into consideration your comparative negligence. You must sign and deliver to the Claims Administrator, Delta Dental, any legal papers relating to the recovery, help exercise these rights and do nothing to harm these rights. If you are fully compensated for all expenses, you must repay the Plan to the extent of the Plan's claim payments.

Date: 09/26/2022

III. Claims Procedures

Claims Administrator Liability

Delta Dental serves only as the Claims Administrator for this Plan. In no instance is Delta Dental liable for any conduct, including but not limited to tortious conduct or wrongful acts or omissions, by any person providing services to subscribers and covered dependents under this Plan, including but not limited to providers, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services. In no instance is Delta Dental liable for services of facilities that, for any reason, are unavailable to a subscriber or covered dependent.

Prior Approval of Benefits

The Plan does not require prior approval of dental procedures; however, you or your provider may request a predetermination of benefits to obtain advance information on the Plan's possible coverage of dental procedures before they are rendered. Payment, however, is limited to the benefits that are covered under the Plan and is subject to any applicable deductibles, copayments, coinsurance, waiting periods, and annual and lifetime benefit maximums.

How to Contest a Claim Denial

Denial of a Claim for Benefits

If you make a claim for benefits under this group dental Plan and your claim is denied in whole or in part, you and your provider, will receive written notification within 30 days after your claim is received, unless special circumstances require an extension of time for processing. The decision will be sent on a form entitled "Explanation of Benefits."

If additional time is necessary for processing a claim for benefits, the Claims Administrator, Delta Dental will notify you and your provider of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either you or your provider did not submit information necessary to make a benefits determination, the notice of extension will describe the required information. You will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact Delta Dental at 800-236-3712. Because most questions about benefits can be answered informally, the Plan encourages you first to try resolving any problem by talking with Delta Dental. However, you have the right to file an appeal requesting that the Plan formally review the benefits determination.

To appeal a benefits determination, contact Delta Dental's Benefit Services Department at 800-236-3712, fax your request to 715-343-7616, or mail your request to Delta Dental, P.O. Box 828, Stevens Point, WI 54481. Provide the reasons why you disagree with the benefits determination and include any documentation you believe supports your claim. Be sure to include the subscriber's name, the covered dependent's name if applicable, and the subscriber's member number on all supporting documents.
You must make your request within 180 days of the date of the initial benefits determination denying your claim for benefits.

Delta Dental will acknowledge your written request for review within five days of receiving it. Upon your request, Delta Dental will provide you, free of charge, access to and copies of all documents, records, and other information relevant to your claim for benefits.

Within 30 days of receiving your request, Delta Dental will send you the Plan's written decision and indicate any action the Plan has taken. (Special circumstances may require 60 days.)

You have the right to appear in person before Delta Dental's Grievance Committee to present written and oral information and ask questions of the persons responsible for the determination that resulted in the grievance. Delta Dental will provide you with written notice of the meeting place and time at least seven days before the meeting.

Delta Dental will provide you or your authorized representative with written notice of the Plan's decision on the appeal. If the appeal is denied in whole or in part, that notice will include the following information.

1. The specific reason(s) for the denial of the appeal;
2. Reference to the specific Plan provision(s) on which the denial is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim;
4. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;
5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;
6. If the denial of the appeal was based on a dental necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

If you do not exhaust the appeal procedures described above, and if you file a lawsuit against the Plan seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize these claims appeal procedures. Also, no legal action can be brought later than three years after the date of the final decision on the review of the benefits determination.

If you have any questions, please contact the Claims Administrator:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
800-236-3712 or 715-344-6087

IV. Statement of ERISA Rights

As a covered person in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all covered persons in the Plan shall be entitled to:

Receive Information about Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each employee or retiree with a copy of the Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the sections of this Plan and Summary Plan Description governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for covered persons under the Plan, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other covered persons and beneficiaries. No one, including the employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek

assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PROTECTED HEALTH INFORMATION PROVISION

1. **Permitted and Required Uses and Disclosure of Protected Health Information**. Subject to obtaining written certification pursuant to paragraph 3 of the Plan, the Plan may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

    a. To perform Plan Administrative Functions which the Plan Sponsor performs for the Plan.

    b. Obtaining premium bids from insurance companies or other health plans for providing insurance coverage under or on behalf of the group health plan; or

    c. Modifying, amending, or terminating the group health plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

2. **Conditions of Disclosure**. The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:

    a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

    b. Ensure that any agents, including independent contractors, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information.

    c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

    d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

    e. Make available to individual plan members their own Protected Health Information in accordance with 45 CFR §164.524, if so requested by the member.

    f. Allow the individual plan member to request an amendment to their Protected Health Information if so requested, and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.

    g. Make available to individual plan members who request an accounting of disclosures of the participant's Protected Health Information, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

i. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the 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 infeasible. Ensure that the adequate separation between Plan and Plan sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied and that terms set forth in Section 5 of this Amendment are followed.

3. **Certification of Plan Sponsor**. The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this Amendment.

4. **Permitted Uses and Disclosure of Summary Health Information**. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

   a. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

   b. Modifying, amending, or terminating the Plan.

5. **Adequate Separation Between Plan and Plan Sponsor**. The Plan Sponsor shall only allow System Director of Total Rewards, Manager – System Total Rewards, Senior Financial IT Analyst and Director of Finance access to the Protected Health Information. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to Plan sponsors employee discipline and termination procedures.

HIPAA Medical Privacy Definitions

Covered Entity means:

- A health plan;
- A health care provider who transmits any health information in electronic form in connection with a covered transaction. (See definition of transaction); or
- A health care clearinghouse (that handles electronic claims from a provider).

Business Associate

A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Health Plan

Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulation, 65 Fed. Reg No. 250 (82463).

Plan Sponsor

Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

Plan Administrative Functions

Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or between Covered Entities or business associates of a Covered Entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Protected Health Information

Information that is created or received by Plan, or a business associate of the Plan, whether in oral, written, or electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased. The following components of a member's information also are considered Individually Identifiable health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member's receipt of healthcare treatment, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary Health Information

Information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.