BOARD OF DIRECTORS REGULAR MEETING
KEWADIN CASINO AND CONVENTION CENTER
SAULT STE. MARIE, MICHIGAN
MINUTES
DECEMBER 3, 2013

The meeting was opened at 6:05 p.m. by Chairperson Payment.

Present: Dennis McKelvie, Deb Pine, Jennifer McLeod, DJ Malloy, Lana Causley, Catherine Hollowell, Keith Massaway, Bridgett Sorenson, Denise Chase, Darcy Morrow, Joan Anderson, Aaron Payment.

Absent: Cathy Abramson – Washington D.C.

Moved by Director Malloy, supported by Director McLeod, to excuse Director Abramson from the meeting.

Motion carried unanimously.

Moved by Director Hollowell, supported by Director Massaway, to excuse Directors Abramson and Causley from last week's meeting, Nov. 26, 2013.

Motion carried unanimously.

Moved by Director Pine, supported by Director Malloy, to approve the agenda as read.

Motion carried unanimously.

Moved by Director Malloy, supported by Director McKelvie, to suspend the rules and add the resolution Amending Tribal Code Chapter 10.

Roll Call Vote: Motion carried with Directors Hollowell, McLeod, Anderson, Malloy, Pine, McKelvie approving, Directors Sorenson, Morrow, Causley, Chase, Massaway opposing.

Moved by Director McKelvie, supported by Director Hollowell, to recess to Membership Issues.

Roll Call Vote: Motion denied with Directors Hollowell, Malloy, McKelvie, Massaway approving, Directors McLeod, Sorenson, Anderson, Pine, Morrow, Chase opposing, Director Causley abstaining.

Without objection – there will be a five minute recess.

Moved by Director Causley, supported by Director McKelvie, to approve Res. 2013-253, Partial Waiver of Convictions for Mr. Darren Bouschor.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors, pursuant to Tribal Code Chapter 76 grants a partial waiver to Mr. Darren Bouschor for the convictions of: Misdemeanor Larceny - $200-$1000 – 2/2011.

Motion carried unanimously.

Moved by Director Causley, supported by Director Pine, to approve Res. 2013-254, Partial Waiver of Convictions for Mr. Travis Gardner. good does not require that she be denied a license as a key employee or primary management official.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors, pursuant to Tribal Code Chapter 76 grants a partial waiver to Mr. Travis Gardner for the convictions of: Larceny from a Building – 10/2012.

Motion carried unanimously.

Moved by Director Sorenson, supported by Director Hollowell, to approve Res. 2013-255, Re-Affirmation of Intent to Maintain the Epoufette Harbor Site and Provide Access to the Public in Accordance with Terms of the Great Lakes Fishery Trust Grant Contract.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors of the Sault Ste. Marie Tribe of Chippewa hereby re-affirms its commitment to adhere to the terms and spirit of Trust's Access Site grant policies to both maintain the Epoufette Harbor site, and to allow public access to the harbor, in accordance with conditions indicated in the grant contract and Trust policies, and regardless as to whether the property is placed into federal trust status in the future.

Motion carried unanimously.

Moved by Director McLeod, supported by Director Hollowell, to approve Res. 2013-256, Opposing Sale or Exchange of Public Lands to Graymont.

NOW, THEREFORE, BE IT RESOLVED, the Board of Directors hereby declares its opposition to the proposed transfer of public lands near Rexton in the Eastern; Upper Peninsula to Graymont; and
BE IT FURTHER RESOLVED, that the Chairperson and/or appropriate staff are directed to seek formal consultation with the State with respect to this issue.

Motion carried unanimously.

Moved by Director Massaway, supported by Director McKelvie, to approve Res. 2013-257, Indirect Cost FY 2014 Budget Modification.

BE IT RESOLVED, that the Board of Directors of the Sault Ste. Marie Tribe of Chippewa Indians here by approves the budget modification to the FY 2014 budget for Indirect Cost to reduce Indirect Revenues monies $157,817 and increase Tribal Support $157,817.

Roll Call Vote: Motion carried unanimously.

Moved by Director Massaway, supported by Director Malloy, to approve Res. 2013-258, St. Ignace Elder Meals FY 2014 Budget Modifications.

BE IT RESOLVED, that the Board of Directors of the Sault Ste. Marie Tribe of Chippewa Indians here by approves the FY 2014 budget modification to St. Ignace Elder Meals decreasing Tribal Support $3,678.58 to reflect the change in positions budgeted.

Motion carried unanimously.

Moved by Director McKelvie, supported by Director Chase, to approve Res. 2013-259, 2014 Travel Budget for the Tribal Chairperson.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors of the Sault Ste. Marie Tribe of Chippewa Indians hereby directs the establishment of a travel budget for the Tribal Chairperson in the amount of $10,000 for calendar year 2014, to be funded from tribal support provided that (1) any expenditure of such these funds must comply with all applicable tribal policies related to travel and (2) these funds shall be expended only as a last resort when other funds are not available to cover the travel expenses of the Chairperson.

Roll Call Vote: Motion carried with Directors Hollowell, McLeod, Sorenson, Anderson, Malloy, Morrow, McKelvie, Causley, Chase, Massaway approving, Director Pine abstaining.

Moved by Director Malloy, supported by Director Sorenson, to approve Res. 2013-260, Opposition to "Fracking".

IT IS THEREFORE RESOLVED, that the Sault Ste. Marie Tribe of Chippewa Indians is deeply concerned by the potentially irreversible damage that could be caused to our water systems and supplies by hydraulic fracturing or "fracking" of shale for the commercial extraction of natural gas and strongly urges the Michigan Legislature and Governor to place a moratorium on any new "fracking" activities until the safety of the processes and its related chemicals have been fully investigated and vetted by the State of Michigan's Department of Environmental Quality and U.S. Environmental Protection Agency.
IT IS FURTHER RESOLVED, the Sault Ste. Marie Tribe of Chippewa Indians supports ongoing federal and state efforts to regulate "fracking" and encourages Congressional leaders to reintroduce the FRAC Act and the BREATHE Act.
IT IS FURTHER RESOLVED, copies of this resolution will be sent to the Michigan Legislature and Governor immediately.

Motion carried unanimously.

Moved by Director Sorenson, supported by Director Hollowell, to approve Res. 2013-261, Approving 2014 Plan Document and Summary Plan Description.

NOW THEREFORE BE IT RESOLVED that the Plan and SPD is hereby amended effective January 1, 2014, as follows:
Section 3.2(a) is deleted and replaced with the following:
3.2 Contributions for the Cost of Coverage
You and your Employer share in the cost of your benefits coverage. You contribute toward the cost by making a Participant Contribution. When you utilize benefits, you are responsible for any co-pays, deductibles, and co-insurance.
a. Employee Medical Contributions
You and the Employer share in the cost of your health care coverage while you are working. When you enroll in coverage, you authorize the Employer to make payroll deductions for your share of the cost.
The level of benefits and the employee contributions required for health care coverage are subject to change at the discretion of the Employer. The Employer currently pays the majority of the cost for health care coverage. Your share is the remaining cost for the coverage.
The exact amount you pay depends on, among other things, the annual salary you earn and the number of your Eligible Dependents. All of your wages are factored in when determining the amount of your premium including tips, bonuses and commissions. If two employees of the Employer are married to each other, the premium for coverage will be based on the wages of the higher wage earner regardless of which employee elects the coverage. A Variable Hour Employee's premium is based on wages earned during an Initial or Standard Measurement Period. In the event that measurement periods overlap, an employee's premium will be based on wages earned during the most recent measurement period.
Payroll deductions are taken each and every pay period in which coverage is in effect. Your annual Benefits Enrollment Guide lists the rates for the upcoming Plan Year.
Sections 4.1 and 4.2 are deleted and replaced with the following:
4.1 Eligible Employees
You are eligible to Enroll in this Plan for medical, prescription drug, dental, and vision coverage if you are an active, regular full-time employee of Employer and regularly work 30 or more hours per week. See Section 21, *Definitions,* for a more detailed definition of Eligible Employee, particularly with respect to who is not an Eligible Employee.
4.2 Effective Date of Coverage
Governmental Employees, Casino Employees and Enterprise Employees are eligible for coverage following a waiting period that varies as explained below. You must enroll for coverage within 30 days of your eligibility date.
4.2 (a) Regular, full-time employees (excluding Seasonal Employees and Variable Hour Employees)
If upon your hire date, you are reasonably expected to be a regular full-time Eligible Employee (i.e., working on average of at least 30 hours per week) and you are not a Seasonal Employee or Variable Hour Employee, the Measurement Periods and Stability Periods discussed further below do not apply to you, and the length of your waiting period is based on your hire date. If you are hired on the first, second or third day of a month, you are eligible for coverage on the first day of the month in which your 2-month anniversary date falls. Otherwise, your coverage is effective on the first day of the month in which your 3-month anniversary date falls.

Eligibility Date for Regular, Full-time Eligible Employees

Excluding Seasonal and Variable Hour Employees

- If you are hired January 4 through February 3, you are eligible for coverage effective April 1.
- If you are hired February 4 through March 3, you are eligible for coverage effective May 1.
- If you are hired March 4 through April 3, you are eligible for coverage effective June 1.
- If you are hired April 4 through May 3, you are eligible for coverage effective July 1.
- If you are hired May 4 through June 3, you are eligible for coverage effective August 1.
- If you are hired June 4 through July 3, you are eligible for coverage effective September 1.
- If you are hired July 4 through August 3, you are eligible for coverage effective October 1.
- If you are hired August 4 through September 3, you are eligible for coverage effective November 1.
- If you are hired September 4 through October 3, you are eligible for coverage effective December 1.
- If you are hired October 4 through November 3, you are eligible for coverage effective January 1.
- If you are hired November 4 through December 3, you are eligible for coverage effective February 1.
- If you are hired December 4 through January 3, you are eligible for coverage effective March 1.

If you were hired prior to January 1, 2014, as a regular full-time employee working 30 or more hours, but you did not meet the Waiting Period requirements under the prior plan, you will become eligible for coverage on the earlier of: the eligibility date specified under the 2012 plan or this Plan.

4.2(b) New Variable Hour Employees and Seasonal Employees

You are a New Variable Hour Employee if you are an Eligible Employee but based on the facts and circumstances on your hire date, the Employer cannot determine whether you will work an average of 30 hours per week during your first 12 months of employment. You are a Seasonal Employee if you are employed during a certain season or period of the year for a job which by its very nature may not be carried on throughout the year. See Section 21, *Definitions*, for a more detailed definition of "Seasonal Employee" and "Variable Hour Employee."

If you are a Variable Hour Employee or Seasonal Employee, your paid hours will be added up and averaged for your first 12 months of employment (i.e., your Initial Measurement Period) in accordance with governing regulations. If you average 30 or more hours of service per week during your Initial Measurement Period, you will be eligible for coverage throughout a 12-month Stability Period. As long as you remain employed, you will be covered throughout the Stability Period.

The Stability Period will commence immediately following the Initial Measurement Period and Administrative Period. The Administrative Period begins the day after your 12-month Initial Measurement Period and ends on the last day of the first full month following your Initial Measurement Period.

Example of Initial Measurement Period (*Are you full-time?*), Administrative Period (*waiting period*) and Stability Period (*period you may be covered*) for a Variable Hour Employee

Hired: March 15, 2014.

Initial Measurement Period: March 15, 2014 through March 14, 2015 (averages 30 hours per week)

Administrative Period: March 15, 2015 through April 30, 2015 (enrolls in coverage)

Covered through out Initial Stability Period: May 1, 2015 through April 30, 2016 (remains employed)

If the employment position or employment status of a New Variable Hour Employee or New Seasonal Employee materially changes before the end of the Initial Measurement Period in such a way that, if the employee had begun employment in the new position or status, the employee reasonably would have been expected to average at least 30 hours of service per week (i.e., would not have been treated as a Variable Hour Employee or Seasonal Employee), the employee will be considered a full-time employee eligible for coverage on—

(i) the first day of the fourth month following the change in employment status, or

(ii) if earlier and the employee averages at least 30 hours of service per week during the Initial Measurement Period, the first day of the first month following the end of the Initial Measurement Period and Administrative Period.

4.2(c) Ongoing Variable Hour Employees

A New Variable Hour Employee becomes an Ongoing Variable Hour Employee once the employee has been employed for at least one complete Standard Measurement Period that is, employed continuously October 15 (Year 1) through October 14 (Year 2).

If you are an Ongoing Variable Hour Employee, your paid hours will be added up and averaged each Standard Measurement Period of October 15 through October 14 (i.e., look-back period) in accordance with governing regulations. If you average 30 or more hours of service per week during a Standard Measurement Period, you will be eligible for coverage throughout a 12-month Stability Period (i.e., look forward period) that runs January 1 through December 31. As long as you remain continuously employed, you will be covered throughout the Stability Period regardless of the number of hours you work.

The Stability Period will commence immediately following the Standard Measurement Period and an Administrative Period that runs October 15 through December 31.

In order to align the Standard Measurement Period with the Employer's payroll periods, the Employer may exclude the payroll period that includes January 1 and include the payroll period that includes December 31 for purposes of calculating average hours worked during a Standard Measurement Period.

If an Ongoing Variable Hour Employee's employment status changes before the end of a Stability Period, the change will not affect the classification of the employee as a full-time employee (or not a full-time employee) or coverage eligibility for the remaining portion of the Stability Period.

Examples of Standard Measurement Period (*full-time?*), Administrative Period (*waiting period*) and Stability Period (*period covered*) for an Ongoing Variable Hour Employee
Initial Period of Coverage ***Averages 30 hours or more per week…*** Hired: March 15, 2014. Initial Measurement Period: March 15, 2014 through March 14, 2015 (averages 30 hours per week) Administrative Period: March 15, 2015 through April 30, 2015 (enrolls in coverage) Covered through out Stability Period: May 1, 2015 through April 30, 2016 (remains employed) **Subsequent Period of Coverage** ***If average 30 hours or more per week…*** Standard Measurement Period: October 15, 2014 through October 14, 2015 (averages 30 hours per week) **Subsequent Period of Coverage** ***If average 30 hours or more per week…*** Standard Measurement Period: October 15, 2014 through October 14, 2015 (averages 30 hours per week) Administrative Period: October 15, 2015 through December 31, 2015 (remains enrolled in coverage) Covered throughout Stability Period: January 1 through December 31, 2016
If averages less than 30 hours per week… Standard Measurement Period: October 15, 2014 - October 14, 2015 (averages under 30 hours per week)

Administrative Period: October 15, 2015 through December 31, 2015 (remains enrolled in coverage) Stability Period: January 1 through December 31, 2016 (doesn't meet eligibility requirements) Coverage ends at midnight on April 30, 2016 (earned coverage through this date based on hours worked during the Initial Measurement period)

If the employee qualifies as full-time during the Initial Measurement Period, the employee retains that status for the entire Stability Period related to the Initial Measurement Period—even if the employee did not qualify as full-time during the Standard Measurement Period. In contrast, if the employee did not qualify as full-time during the Initial Measurement Period but does so qualify during the Standard Measurement Period, the employee must be treated as full-time for the full Stability Period associated with the Standard Measurement Period—even if that means the employee is eligible for coverage before the end of the Stability Period associated with the Initial Measurement Period. That is, the employee's change to full-time status overrides the initial determination, and the employee must be treated as full-time even if there was time remaining in the Stability Period associated with the Initial Measurement Period.

4.2(d) Employees Rehired After Termination of Employment

Subject to the special rules described above, an employee generally will retain full-time or non-full-time employee status during an entire Stability Period as long as the employee continues to be employed. Under the Rule of Parity, if an employee terminates employment and is subsequently rehired, the employee will be treated as a new employee if the period (measured in weeks) during which no services are performed is at least four weeks long and exceeds the number of weeks of employment immediately preceding the period during which no services are performed.

4.2(e) Regular Full-Time Employees, Seasonal Employees and Variable Hour Employees

IF YOU DO NOT ENROLL IN THE PLAN ON A TIMELY BASIS (WITHIN 30 DAYS AFTER YOUR DATE OF ELIGIBILITY), YOU WILL RECEIVE NO COVERAGE. YOU WILL NOT BE ELIGIBLE FOR HEALTHCARE COVERAGE UNDER THIS PLAN

UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD, UNLESS YOU BECOME ELIGIBLE FOR SPECIAL ENROLLMENT UNDER SECTION 4.6.

If you Enroll your Eligible Dependents in this Plan, their Effective Date of Coverage is the same as yours. If any of your Eligible Dependents are in a hospital on the date that your enrollment in this Plan is effective, this Plan will be secondary to any coverage until such time as such Eligible Dependent is discharged from the hospital.

The Emergency Care Section in Table 6.5 is deleted and replaced with the following:

EMERGENCY SERVICES		
Emergency Services (Hospital Emergency Room --Non-Emergency use of an Emergency Room is not covered. --Co-pay waived if "admitted" to hospital.	100% after deductible after $100 co-pay	100% after deductible after $100 co-pay
Urgent Care Facility	80% after deductible	65% after deductible
Ambulance – medically necessary transport	80% after deductible	80% after deductible

The following services are added to Table 6.5:

CLINICAL TRIALS		
Clinical trials for Cancer or other life threatening diseases or conditions per PPACA	Subject to cost sharing. Refer to the specific services for cost sharing information.	Subject to cost sharing. Refer to the specific services for cost sharing information.

Section 6.6.1 is deleted and replaced with the following:

6.6.1 When Pre-Verification Claim review is Recommended

Generally, Pre-Verification Claim review is recommended for any kind of inpatient hospital stay, inpatient and outpatient surgery and for a number of specific tests and procedures. If you have any reservation whether or not services should be Pre-Verification Claim reviewed, you should contact the member services representative at the number on your identification card. If possible, you should request a Pre-Verification Claim review at least 14 days before the date of an elective admission or proposed treatment. In instances where it is not possible to request a Pre-Verification Claim review, we recommend
the following guidelines:

- Five business days before an elective admission
- Within one business day or the same day as a non-elective admission

For any of the following:

- Admission to a hospital, skilled nursing, convalescent or rehabilitation facility or any other inpatient admission
- for any form of treatment, including mental health and/or substance abuse
- Admission for inpatient hospice care
- Home health care services
- Private duty nursing
- Inpatient or outpatient surgery

Benefits for any of the above are reviewed for a specific duration of time. If your treatment takes longer than originally expected or you need additional services, an additional review is required.

Typically this plan will pay for a confinement of 48 hours or less for a vaginal delivery or for a confinement of 96 hours or less following a cesarean delivery as related to Maternity. If your inpatient stay will extend beyond the limitations stated above, your provider should call to certify the additional days.

You also should request Pre-Verification Claim reviews for any of the following procedures (unless they are for Emergency Services performed as part of a covered Hospital Emergency Room visit for an Emergency Medical Condition):

- Back surgery
- Ear, nose and throat surgery
- Female pelvic surgery
- Foot surgery
- Gall bladder surgery
- Hand/wrist surgery
- Heart surgery
- Knee surgery
- Rectal surgery
- Any plastic or reconstructive surgery
- Organ/tissue transplants (at least seven days before any part of the process is initiated or as soon as reasonably possible after the possibility of a transplant arises)

You should also obtain Pre-Verification or Post-Service claim review for any of the following tests, services or supplies:

- Within five business days of any post-emergency dental treatment
- Before any MRA, MRI, PET or CT scan
- Before the commencement of physical, occupational or speech therapy
- Before allergy immunotherapy treatment
- For injectable drugs that require injection by a health care professional

Pre-Verification is not required for any MRA, MRI, PET or CT scan performed as part of a covered Hospital Emergency Room visit for an Emergency Medical Condition or performed during an inpatient Hospital Admission.

<u>Section 6.8.1 is deleted and replaced with the following:</u>

6.8.1 Emergency Room Care

You are covered for the treatment of accidental injuries or conditions that the Third-Party Administrator determines are True (medical) Emergencies. True emergencies are one of the following:

- An accidental injury is physical damage caused by an action, object, or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises; allergic reactions, frostbite, sunburn and sunstroke; swallowing poisons and medication overdosing; and inhaling smoke, carbon monoxide or fumes.

- A medical emergency is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Emergency room services generally are covered as such only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in place of emergency room services. If the Third-Party Administrator, at its discretion, determines that it is not a true emergency and a less intensive or more appropriate treatment could have been given, benefits under the Plan may be reduced or not covered.

Notwithstanding any other Plan provisions, a Participant is also covered for Emergency Services provided in connection with "an Emergency Medical Condition" including medical screening examinations within the capability of a hospital's emergency department including ancillary services routinely available to evaluate an Emergency Medical Condition and further examination and treatment as required to stabilize the patient. An Emergency Medical Condition is evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts. The Third-Party Administrator will have sole discretion in determining what is considered Emergency Services.

In accordance with PPACA:

- Pre-verification (or preauthorization) is not required and Emergency Services provided in a Hospital Emergency Room are covered regardless of whether services are provided by a Network Provider or Non-Network Provider;
- The Plan does not impose any administrative requirement or coverage limitation on Emergency Services provided by a Non-Network Provider that is more restrictive than any administrative requirement or coverage limitations imposed on Emergency Services provided by a Network Provider; and
- The Plan complies with PPACA's cost-sharing requirements.

<u>The following is added as Section 6.14.14, Clinical Trials:</u>

The Plan covers the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements, when delivered by Network Providers:

- evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF);
- 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;
- 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; and
- other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Any recommendations or guidelines issued after September 23, 2009, are covered by the Plan (regardless of whether they are specifically listed in the Plan) beginning with the first full Plan Year that begins one year after the recommendation or guideline is published.

Depending on the item, preventive services may be covered under the medical or prescription drug section of the Plan.

<u>The following is added as Section 6.14.14, Clinical Trials:</u>

The Plan provides coverage for "Qualified Individuals" participating in "Approved Clinical Trials" including coverage of "Routine Patient Costs" for items and services furnished in connection with an "Approved Clinical Trial" for a "Life-Threatening Condition." The Plan will not:

- deny any qualified individual the right to participate in a clinical trial;
- deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial; or
- discriminate against any qualified individual who participates in a clinical trial.

Qualified Individuals must use Network Providers if available and if the providers will accept the individuals as participants. Otherwise, Qualified Individuals may use Non-Network Providers located in Michigan or any another state.

For purposes of these requirements, the following definitions apply:

"Approved Clinical Trial" is a phase I, II, III, or IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

"Life-threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

"Qualified Individual" is a Plan Participant who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other life-threatening disease or condition and either:

- the referring health care professional is a Network Provider and has concluded that the Plan Participant's participation in the clinical trial would be appropriate; or
- the Plan Participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

"Routine Patient Costs" include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include:

(a) the investigational item, device or service itself;

(b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or

(c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

The Plan contains various exclusions for experimental or investigative treatments, including, for example, with respect to Human Organ Transplants, Chemotherapy, Bone Marrow Transplants and drugs not yet approved by the FDA). Such exclusions will not apply to items and services rendered as part of an Approved Clinical Trial.

Section 6.15, Medical Exclusions and Limitations, is updated as follows:

The exclusion of "Charges for emergency or urgent care that is determined not to be a true emergency" and the exclusion of "Charges for medical, surgical, or other healthcare procedures and treatments which are experimental or investigational…" are replaced with the following:

- Charges for emergency or urgent care that is determined not to be either a true emergency or an Emergency Medical Condition (per PPACA).
- Charges for medical, surgical, or other healthcare procedures and treatments which are experimental or investigational, as determined by the Plan in accordance with consensus derived from peer review medical and scientific literature and the practice of a national medical community (but excluding changes that fall under an Approved Clinical Trials).

Section 7.7, What's Not Covered: Prescription Drugs, is updated as follows:

The exclusions for "Charges for experimental drugs…" and "Procedures, services, drugs and other supplies…" are replaced with the following:

- Charges for experimental drugs or substances not approved by the Food and Drug Administration (FDA) or limited by federal law for experimental or investigational use, including drugs labeled "caution-limited by federal law to investigational use" but excluding any drugs that are part of an Approved Clinical Trial.
- Procedures, services, drugs and other supplies that are, as determined by the claims administrator, experimental or still under clinical investigation by health professionals unless they are part of an Approved Clinical Trial.

The second paragraph in Article 10 is deleted and replaced with the following:

You have the option of contributing up to $2,500 each Calendar Year to the Health Care FSA that you will not have to pay taxes on. You may use the money only for Eligible Expenses that you incur during the same Calendar Year (except with respect to "carry over" amounts).

Carry Over Amounts. If you have unused funds following the 2 ½ month run-out period for a Plan Year, up to $500 of your unused health FSA balance will automatically carry over to the next Plan Year. Unused amounts in excess of $500 forfeit to the Employer after the 2 ½ month run-out period for a Plan Year. Amounts carried over cannot be cashed out or converted to any other taxable or nontaxable benefit and will not count against your annual health FSA salary reduction limit of $2,500. You can carry over up to $500 and still elect to contribute $2,500 to a Health FSA Account. Unused carryovers remaining at termination of employment are forfeited (unless you elect COBRA).

Example of How the Carry Over Works

If you contributed $2,500 for the 2013 Plan Year and you incurred Eligible Expenses in the total amount of $1,900 for services rendered in 2013:

- You will be reimbursed $1,900 as long as you apply for reimbursement and submit copies of any required receipts on or before March 15, 2014.
- $500 will carry over to the 2014 Plan Year.

- You will forfeit $100.
- You're eligible to contribute $2,500 for the 2014 Plan Year.
- This would leave you with an available balance in 2014 of $3,000.

The description of "Important Dates" in Section 10.1 is deleted and replaced with the following:

Important Dates	-- Incur expenses during Plan Year (*January 1, 2013 -- December 31, 2013*) -- The Plan's Run Out Period allows an extra 2½ months (e.g., January 1 to March 15, 2014) to report expenses incurred during the Plan Year (e.g., the 2013 Plan Year) and to be reimbursed from any unused balances for the Plan Year (e.g., 2013 Plan Year). If you have money remaining in your account after the March 15 deadline to submit expenses, it will be forfeited (except for any Carry Over amount).

The last paragraph in Article 10 is deleted and replaced with the following:

When you set aside funds into the Health Care FSA, you may withdraw money from your Health Care FSA to pay for Eligible Expenses that you incur during the Calendar Year (or during the following Calendar Year for any carry amounts), as long as the expenses are for you or an Eligible Dependent.

The following provisions are added to Section 18.11, The Patient Protection and Affordable Care Act, as amended ("PPACA"):

Effective on January 1, 2011, the following provision applies to this Plan:

10. patient protections (choice of health care professional and coverage of emergency services).

Changes effective in 2014 include:

6. Clinical trial coverage; and
7. Cost-sharing limits.

The following definitions are added to Article 21:

Administrative Period. The *Administrative Period* is a period after the end of a Measurement Period—and before the beginning of the next Stability Period—during which the Employer can perform administrative tasks, such as calculating the hours for the Measurement Period, determining eligibility for coverage, providing enrollment materials to Eligible Employees, and conducting open enrollment.

Initial Measurement Period. A 12-month *Initial Measurement Period* is used for New Variable Hour Employees and New Seasonal Employees beginning on their hire date.

Measurement Period. A *Measurement Period* is the look-back period over which hours are calculated to determine whether an employee has averaged at least 30 hours per week. There are two types of measurement periods: Standard Measurement Periods and Initial Measurement Periods.

New Seasonal Employee. A *New Seasonal Employee* is an employee who has not been employed for at least one complete Standard Measurement Period.

New Variable Hour Employee. A *New Variable Hour Employee* is an employee who has not been employed for at least one complete Standard Measurement Period.

Ongoing Variable Hour Employee. An *Ongoing Variable Hour Employee* is an employee who has been employed for at least one complete Standard Measurement Period.

Seasonal Employee. A *Seasonal Employee* is employed during a certain season or period of the year for a job which by its nature may not be continuous or carried on throughout the year.

Stability Period. The 12-month Stability Period is the look-forward period for which an employee's status (determined during the Measurement Period as full-time or not) is locked in, regardless of the employee's actual hours during this period (provided that the employee continues to be employed). The Stability Period begins at the end of the Measurement Period (and the Administrative Period).

Standard Measurement Period. A 12-month *Standard Measurement Period* running from October 15 through October 14 is used for ongoing employees. The Standard Measurement Period for the 2014 Plan Year is October 15, 2012 through October 14, 2013.

Variable Hour Employee. An employee is a *Variable Hour Employee* if it cannot be determined on the employee's start date that the employee is reasonably expected to work an average of at least 30 hours per week during the Initial Measurement Period (based on the facts and circumstances on the employee's start date).

The following definitions in Article 21 are updated as follows:

Eligible Employee. *Eligible Employee* means any employee who, in accordance with the personnel policies of the Employer, is a full-time regular employee who works 30 or more hours per week (during an Initial Measurement Period or Standard Measurement Period for Variable Hour Employees or Seasonal Employees) for the Employer and who is not an excluded employee as provided in this Section.

The following shall be excluded employees and shall not be eligible to participate in this Plan: Full-time regular employees scheduled to work less than 30 hours per week (excluding Seasonal Employees and Variable Hour Employees who average 30 or more hours during an Initial Measurement Period or Standard Measurement Period); part-time employees, casual employees; temporary employees; freelancers; employees covered by a collective bargaining agreement which does not specifically provide for coverage under this Plan; any person, including a common law employee of the Employer, who provides services to the Employer if such services are provided pursuant to an agreement between the Employer and any person (such as an employee leasing or employee staffing organization) that has not adopted this Plan; and any individual who is listed on the books and records of the Employer as an independent contractor and for whom the Employer does not report wages on Form W-2 (or successor form), regardless of whether such individual is, at any time, determined by any court, governmental agency, or otherwise to be a common law employee of the Employer. An individual who is characterized by the Employer on its records as other than an Eligible Employee is not eligible to participate in this Plan for any period of time during which he or she is so characterized.

Medically Necessary, Medically Necessary Care and Treatment. *Medically Necessary* means a service or supply that meets the following criteria:

- It is provided to
  - Treat a life-threatening condition, or
  - Treat pain, Injury, or infection, or
  - Treat a condition that would result in physical or mental Disability;
  - To improve physical or mental function; or
  - To treat an Emergency Medical Condition.
- It is consistent with:
  - Generally accepted current medical practice, or
  - The medical standard of the community for the diagnosis or condition
- It is consistent in type, frequency and duration of Treatment with scientifically-based guidelines of:
  - National medical, research or health care coverage organizations, or
  - Governmental agencies

In no event will the Plan consider services or supplies to be Medically Necessary if:

- They are chiefly custodial in nature, or
- They are experimental or investigative (except with respect to Approved Clinical Trials), or
- They are not proven to be medically effective, or
- They are provided for the personal comfort or convenience of a person, or
- They are primarily to improve, alter, or enhance appearance, or
- There is another equally effective or suitable alternative that is more conservative or less expensive (except with respect to Emergency Services provided in a Hospital's emergency room to stabilize a patient with an Emergency Medical Condition).

The fact that any particular provider may prescribe, order, recommend, or approve a service, supply or level of care does not, of itself, make such Treatment Medically Necessary.

The definition of Medically Necessary stated in this document relates only to the Plan's benefit Payments and differs from the way in which a provider engaged in the practice of medicine may define "medically necessary."

Spouse. *Spouse* means the person who is married to you in a legally recognized civil or religious ceremony. The Plan does not recognize common law marriages. You must furnish a copy of your marriage certificate. If you become divorced or legally separated, your Spouse loses eligibility.

Roll Call Vote: Motion carried with Directors Hollowell, McLeod, Sorenson, Anderson, Malloy, McKelvie, Massaway approving, Directors Pine, Morrow, Causley, Chase opposing.

Moved by Director McKelvie, supported by Director Malloy, to accept the resignation of Norma Castro from the Cultural Committee, effective immediately.

Motion carried with Directors Hollowell, Pine, Causley opposing.

Moved by Director McKelvie, supported by Director Morrow, to accept the resignation of Tony Grondin from the Cultural Committee, effective immediately.

Motion carried with Directors Hollowell, Sorenson, Pine, Causley opposing.

Moved by Director Sorenson, supported by Director Morrow, to appoint Reinette Murray to the Health Board, for a four year term, expiring December 2017.

Motion carried unanimously.

Moved by Director Sorenson, supported by Director Morrow, to appoint Director Massaway, to the Cultural Committee, to fill a Board of Directors seat.

Without objection, will table until the end of the agenda. No objections.

Moved by Director Chase, supported by Director Malloy, to table the issue of hearing aids.

Motion carried unanimously.

Moved by Director Malloy, supported by Director Hollowell, to suspend the rules and add the resolution 2012-216-Out of State Travel by the Board and Chairperson.

Roll Call Vote: Motion denied with Directors Pine, Massaway, Causley, Hollowell, McKelvie, Malloy approving, Directors Anderson, Chase, Sorenson, Morrow, Malloy, McLeod opposing. Needed to be approved by a vote of at least nine approving.

Moved by Director Causley, supported by Director Hollowell, to appoint Director Massaway, to the Cultural Committee, to fill a Board of Directors seat.

Motion carried with Director Malloy opposing, Director Massaway abstaining.

Moved by Director McKelvie, supported by Director Massaway, to adjourn the meeting.

Motion carried with Directors Causley, Hollowell opposing.

Meeting adjourned: 7:24 p.m.

Date: 2-18-14 Secretary: Cathy Gramson

Others present: John Wernet, Bill Connolly, Christine McPherson, Russ McKerchie, Courtney Kachur, Jennifer Tadgerson, Justin Derhammer, Bob Marchand, Joanne Carr.