Village of Menomonee Falls
Health Expense Reimbursement Option Plan
(HERO Plan)
Summary Plan Description

Your employer is pleased to provide the Village of Menomonee Falls Health Expense Reimbursement Option Plan (HERO Plan) for Eligible Employees. Under federal tax law, the HERO Plan is known as a “Health Reimbursement Arrangement” or “HRA” plan. The HERO Plan is integrated with the Village of Menomonee Falls spouse of the employee’s High-Deductible Health Coverage Plan (the HDHC Plan). Participation in this Plan does require you to be enrolled and participating in your spouses’s HDHC Plan concurrent with your enrollment and participation in this Plan. If you elect to enroll your dependents in this Plan, you are required to have enrolled your covered dependents in your spouse’s HDHC Plan at the same time.

This booklet contains a summary in English of your plan rights and benefits under the Village of Menomonee Falls Health Expense Reimbursement Option Plan (HERO Plan). If you have difficulty understanding any part of this booklet, contact the benefits department of Village of Menomonee Falls at W156N8480 Pilgrim Rd, Menomonee Falls, WI 53051.

This is only a summary of the Benefit Plan. A copy of the Plan Document, containing more detail, is available from the Plan Administrator upon your request. If there is a conflict between the official, complete HERO Plan Document and this summary, the official HERO Plan Document will control.

This Plan is established by the above named employer and is the only employer offering the benefits of the Plan.

Table of Contents

Plan Purse

The purpose of the HERO Plan is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and Dependents' Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HERO Plan generally are excludable from taxable income.

Who Are Eligible to Enroll in the Plan

Any Employee who meets the eligibility requirement set forth:

- Part-Time employees who work less 40 hours per week are ineligible for this plan.
- Retired employees are not allowed in this plan.
- Former Employees are not allowed in this plan.
- Eligibility is limited to employees waiving coverage under the Village of Menomonee Falls High-Deductible Health Coverage that were previously enrolled in the health plan and newly eligible employees.
- Employees waiving coverage prior to January 1, 2025 must be disenrolled in the Village of Menomonee Falls Health coverage for 12 months before becoming eligible for the HERO Plan.
- The spouse’s HDHC plan must be employer sponsored minimum value coverage. No Medicare, individual plans, etc.
- In a family unit, both employee, spouse and kids are eligible. But only those on the plan currently are eligible for reimbursement. Example: Employee is on a single plan, and their spouse is on their own single plan at their employer, only the employee’s claims are eligible for reimbursement if the employee waives coverage and moves to the spouse’s plan.

How and When to Enroll

After you become eligible, you may enroll in the Plan, subject to your enrollment in the aforementioned spouse’s HDHC Plan. You may request coverage for any dependents, provided such dependents meet the eligibility requirements, and are or will be concurrently enrolled as your dependent(s) in the aforementioned spouse’s HDHC Plan. Your decision must be made during the enrollment period provided by the Plan Administrator. If you are a newly hired employee, you must make your decision during any period immediately preceding your becoming eligible.

If you are already a Plan Participant and you fail to complete an election form for the upcoming Plan year, then you will maintain the enrollment options that you elected for the prior year, until changed by an approved Change of Status election or you elect to suspend or permanently opt-out during open enrollment.

HERO Plan Options and HSA Qualified HDHC Plans

During the enrollment process you must select from one of the 2 plan options:

- Option 1 – No HSA HERO Plan
    - Deductible, Coinsurance and Copayments are eligible for reimbursement as they are incurred without having to meet a minimum annual deductible.
    - Participants lose eligibility to make or receive any contributions into any HSA Account.
- Option 2 – Post Deductible HERO Plan
    - Eligible expenses must be incurred after the participant meets HSA statutory Minimum Annual Deductible based on enrollment level. The minimum deductible for the January 1, 2025 thru December 31, 2025 is $1,650 self only and 3,300 for coverage other than self-only. The Minimum Annual Deductible is adjusted and published by the IRS.

If your spouse's HDHC plan is an HSA qualified High Deductible Health Plan, and you enroll in Option 1 along with your spouse, you and your spouse will not be eligible to make HSA contributions. The HERO Plan Option 1 is considered impermissable coverage and will disqualify you for any HSA contributions including employer contributions.

If your spouse's HDHC plan is an HSA qualified High Deductible Health Plan, and you enroll in Option 2 along with your spouse, the plan is post deductible and will not disqualify you and your spouse from making HSA contributions provided you meet all other HSA eligibility requirements. Medical expenses applied to the statutory minimum deductible do not qualify for reimbursement from the HERO plan Option 2. Documentation showing the deductible has been met must be submitted for subsequently incurred expenses to be eligible for reimbursement.

Change of Status

Only under special circumstances, such as a change in family status, changes in the election of a type of coverage under the plan, and certain other qualifying events, may you apply to change your selected benefits. A changed election under this Plan must be consistent with the changes; to the extent it is necessary or appropriate as a result of

the necessity of a change in the election of benefits under the spouse's HDHC Plan or as a result of a change in accident and health coverage of the Spouse or Dependent.

A Participant entitled to change an election must do so within 30 days of the qualifying event.

A Participant entitled to change an election due to a HIPAA Special Enrollment Event for loss of coverage or becoming eligible for state premium assistance subsidy under a Medicaid plan or state children's health insurance must do so within 60 days of the qualifying event.

Any such elections shall apply for the balance of the Plan Year in which the election is made unless a subsequent event occurs.

If you should terminate your employment and stop your elections under this Plan, you may, if rehired, begin to participate in the Plan again after re-satisfying the eligibility requirements. However, you may not make a new election, which is effective during the Plan Year in which your service with the Employer was terminated.

Election to Suspend or Permanently Opt Out of HERO Account

If you and your spouse or dependents participate in the HERO Plan Option 1, anyone participating will be ineligible to make HSA contributions. You can remove the HERO Plan Option 1 as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your HERO Account before the beginning of that Plan Year. Whether you elect to suspend your HERO Account is up to you.

You may elect to suspend your HERO Plan Option 1 Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your HERO Plan Option 1 Account for a Plan Year, you agree to permanently forgo reimbursements from your HERO Account for Medical Care Expenses incurred during that Plan Year. Medical Care Expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to the Administrator, no later than 90 days following the end of the Calendar Year in which the Medical Care Expense was incurred.

In lieu of a suspension of your HERO Account, you may elect to permanently opt out of and waive any right to reimbursements from your HERO Account for expenses incurred after the election takes effect. This opportunity will be offered at least annually by the HERO Plan. If you permanently opt out of this plan, you will have no opportunity to resume participation in the current plan year or any future plan years.

The Employer will not contribute to your HERO Account after any opt-out election takes effect or for any Plan Year for which you have suspended your participation in the HERO Plan.

Schedule of Benefits

Benefit Credits will be credited to your HERO Plan Account by the Employer. The amount of which are to be credited at a time or times as determined by the Employer. The amount of the Benefit Credits is specified in the Schedule A of this document, with which you are permitted to use to pay for qualified medical expenses not otherwise covered by any other accident or health plan. See Schedule A of this Plan for the available Benefit Credits you may elect.

Health Expense Reimbursement Option Plan (HERO Plan) account: (The "account")

How the Health Expense Reimbursement Option Plan (HERO Plan) account Works.

The Plan Administrator will set up a Health Expense Reimbursement Option Plan (HERO Plan) account for you from which you may be reimbursed for medical expenses you have incurred. The method of substantiating the medical expenses will be determined by the Plan Administrator.

If you enroll your qualified dependents in the Plan, you may be reimbursed for medical expenses. The HERO may only pay Eligible Medical Expenses not previously reimbursed or for which you will not seek reimbursement from any other accident or health plan, cafeteria plan, or health insurance. If an Eligible Medical Expense is payable or reimbursable from another source, that other source must pay or reimburse prior to payment or reimbursement from the HERO Plan. If only a portion of an Eligible Medical Expense is reimbursable by another health plan (e.g., because of copayment or deductible requirements), the HERO Plan can reimburse the remaining portion of the expense if it otherwise meets the requirements of the HERO Plan. However, if Eligible Medical Expenses are covered by both HERO Plan and by a health flexible spending account (health FSA), the HERO Plan will pay first, exhausting all available HERO Plan Credits, before the health FSA may provide reimbursement.

The Employer will maintain this "account" on a memorandum nature for accounting purposes, and will not be representative of any identifiable Trust assets. Benefit Credits withdrawn as requested by the Participant will be debited to the then existing account balance.

The Employer has designated Village of Menomonee Falls to be the claims administrator. Once the claims administrator has received the claims, all claims will be processed for reimbursement on a weekly basis, unless the employer chooses another reimbursement schedule, but at least once per month. If your employer has opted for seamless benefits, your provider will be reimbursed the full amount of your eligible

expenses up to the limit of available Benefit Credits in your Health Reimbursement account, otherwise you will receive the reimbursement and will be responsible to pay your provider. Under this category are medical expenses that are not reimbursed or non-reimbursable under the employer's group HDHC benefit plans. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify.

Village of Menomonee Falls also permits electronic reimbursement of medical reimbursement arrangement account expenses by direct deposit into the bank account of the participant's choice. Participants must complete a Direct Deposit Authorization Form and can change their bank account of choice at any time by submitting a new Direct Deposit Authorization Form. By using direct deposit, a participant will have the convenience of not needing to wait for a check to arrive or be deposited to pay providers for eligible expenses.

Claims Substantiation

If your plan is seamless, the medical claims (not prescriptions) will be received by the administrator from the HDHC carrier, otherwise you may apply for reimbursement by submitting a signed claim form to the Administrator no later than March 31st following the close of the Calendar Year in which the Medical Care Expense was incurred, detailing:

- the individual(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Medical Care Expenses incurred;
- the amount of the requested reimbursement; and
- a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Along with the claim form, submit the HDHC Explanation of Benefits (EOB) along with bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that may be requested. If you have other accident and health plan coverage in addition to the HDHC, you will be required to submit the Explanation of Benefits (EOB) from your other carrier. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $1.

An Explanation of Benefits (EOB) will be generated for each claim processed, including but not limited to claims paid, claims adjusted and claims denied. The EOB will be sent to you by first class mail, or retrieved by you via the Member Portal on the Internet if you elect to have electronic EOBs.

You may continue to submit claims up to three months after the calendar Year end for the prior calendar year's expenses. Employees who terminate employment and participation in this Plan during the Plan Year will be given 90 days from their date of termination in which to submit request for reimbursement for expenses incurred before termination. Any reimbursements from the HERO PLAN Account for Eligible Medical Expenses incurred after the date of termination will be made only pursuant to a COBRA election.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, whether it is due to a mistake as to the eligibility of participation or the allocations made to your HERO PLAN or an adjustment made by the HDHC, you will be required to refund the overpayment or erroneous reimbursement to the HERO PLAN Plan.

If you do not refund the overpayment or erroneous payment, the HERO PLAN Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your compensation.

Claims Appeals

Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If a Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under. Participants will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, the claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: 44North, 1406 N. Mitchell Street, Cadillac, MI 49601, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 60 days after receipt of the appeal. Participants are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participant receives an adverse benefit determination following the final appeal, Participant has the right to bring a civil action under section 502(a) of ERISA. An external review process shall be provided as legally required.

Roll-Over Benefit

At the end of a Plan Year any remaining unused Benefit Credits will be forfeited.

If a Participant is no longer an eligible participant in the Plan, according to the rules of this Plan, the balance of Benefit Credits remaining after all reimbursements have been completed will be forfeited.

Department of The Treasury rules state that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Qualified Medical Child Support Orders (QMCSO)

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. The Plan Administrator will notify you if it received a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Uniformed Service under USERRA

Continued Participation in the Plan is permitted under certain conditions when you are serving in the United States military after having been a Participant in this Plan. See your Plan Administrator for the provisions of this continuation. The current rules are outlined in the (HERO PLAN) Plan Document available from the Plan Administrator.

Participation While on FMLA Leave

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may continue participation in this Plan during the continuation of the current Plan Year, but not beyond. If such participant returns to active employment, the participant will be reinstated, provided the former participant also is reinstated in the spouse's HDHC Plan coincidentally, and in the same manner as existed before the FMLA Leave commenced. The Employer will provide such Benefit Credits that would normally be provided to such Participant during the remainder of the current Plan Year. The Employer or Plan Administrator shall determine the manner in which such Benefit Credits are applied to the Participant's account in its sole discretion.

Future of the Health Expense Reimbursement Option Plan (HERO Plan)

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code, and relevant Department of the Treasury rulings. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you are entitled before the date of the amendment or termination.

Administrative Facts

Plan Sponsor and Administrator

The Health Expense Reimbursement Option Plan (HERO Plan) Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. For purposes of this Plan, the Employer shall serve as the Plan Administrator.

Plan Year

The First Plan Year will begin Wednesday, January 1, 2025, and ends Wednesday, December 31, 2025. The subsequent Plan Year will begin Thursday, January 1, 2026, and will renew every January 1st thereafter.

Prior Calendar Year Claims

Deductibles reset January 1st. Claims can be submitted through March 31st for the prior calendar year. Claims submitted after 90 days (91 days in leap years) are subject to Carrier and Employer approval.

Name of Plan and Employer Plan Identification Numbers

The Name of this Plan is Village of Menomonee Falls Health Expense Reimbursement Option Plan (HERO Plan).

The Employer Identification Number (EIN) assigned to Village of Menomonee Falls by the Internal Revenue Service (IRS) is 39-6006317. The Plan Number (PN) assigned to the Flexible Benefit Plan by the Employer is 501.

Service of Legal Process

Village of Menomonee Falls, the Employer, has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Employer by directing the process to the Plan Administrator indicated above.

Classification and Funding

The Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participant's gross income under Code §105(b). This Plan is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Tech. Rel. 2013-3, through integration with the HDHC Plan. This Plan and the HDHC Plan shall be interpreted to accomplish these objectives.

Each Participant's benefits under the Plan shall be paid from Employer's general assets. Nothing in the Plan shall be construed to require Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

Your Employer funds the full amount of the HERO Plan Accounts. There are no Participant contributions for Benefits under the Plan, except as provided in the case of COBRA coverage. Under no circumstances will the Benefits be funded with salary reduction contributions, employee contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employee contributions to the Plan.

The benefits provided under the Health Expense Reimbursement Option Plan (HERO Plan) are not insured. In the event the Plan or Plan Sponsor does not pay medical expenses that are eligible for payment under the plan for any reason, the participant may be responsible for the expenses.

Third-Party Administrator

The Plan may from time to time employ the services of a Third-Party Administrator (TPA) for designated Plan administration, or other qualified professionals for Plan services, under the direction of the Plan Administrator.

The Plan has contracted with a TPA to administer benefits and process claims. The TPA merely processes claims and does not insure that any medical expenses of individuals covered by the Plan will be paid. Complete and proper claims for benefits made by participants covered by the Plan will be promptly processed; however, in the event there are delays in processing claims, plan participants have no greater rights to interest or other remedies against the TPA except those permitted by law.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Statement of ERISA Rights

"ERISA Rights" means your rights obtained by Federal Law:

Statement of ERISA Rights:

As a participant in the Village of Menomonee Falls Health Expense Reimbursement Option Plan (HERO Plan) you are entitled to certain rights and protection under the Employees Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive information about your Plan and benefits. Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

  Receive a summary of the plan's annual financial report, if one is filed. The plan administrator is required by law to furnish each participant with a copy of this 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 summary plan description (SPD) and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 plan participants and beneficiaries. No one, including your employer, your union, 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 administrator. If you have a claim for benefits that 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 the 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 question about your plan, you should contact the plan administrator. If you have any question about this statement or your rights under ERISA, 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, (EBSA) U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 1-866-444-3272.

Participant's Health Information

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT PLAN PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW PLAN PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a Health Plan subject to HIPAA, the plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations ("Rules") and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH") include privacy protections impacting handling of the group health plan medical or financial information that could identify an individual.

Protected Health Information (PHI) is information created or received by Plans subject to HIPAA that relates to the past, present or, future individual's physical or mental health condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Protected Health Information (PHI) provisions of HIPAA and its rules include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations only upon individual authorization. Regarding their own PHI, they have the right to:

A. Object to using information;

B. Gain access to information;

C. Change information; and

D. Obtain an accounting of any information disclosures.

An underlying principle of the rules is that the "minimum necessary" disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

Participants in this plan are guaranteed access to their PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans' privacy practices. Individuals have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

Certification Requirement

The plan shall disclose PHI, including Electronic PHI, to Authorized Employees of the Employer only upon receipt of a certification by the Employer that the Employer agrees:

A. not to use or further disclose PHI other than as permitted or required by the Privacy Policy or as required by law;

B. to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

C. not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

D. to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures, or any Security Incident, of which the Employer becomes aware;

E. to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

F. to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

G. to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

H. to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

I. if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

J. to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

K. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

Electronic Data Security Obligations

To the extent the Plan maintains electronic PHI, the Plan will:

A. Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;

B. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;

C. Ensure that the separation is supported by reasonable and appropriate security measures;

D. Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

E. Report to the Plan any security incident involving PHI including any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations of which it becomes aware.

Permitted Uses and Disclosures

The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

Only Authorized employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Authorized employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan.

The HIPAA Plan may disclose PHI to the Authorized employees of the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Authorized employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the plan and agree to use and disclose PHI only as permitted or required by HIPAA. This includes:

A. Plan's own Payment and Health Care Operations functions including;

1. Enrollment of eligible individuals;

2. Eligibility determinations;

3. Payment for coverage;

4. Claim payment activities;

5. Coordination of benefits; and

6. Claims appeals.

B. Another HIPAA Health Plan's Payment and Health Care Operations functions;

C. Disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

D. Disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

E. Disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g)

F. Disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

G. Uses and disclosures to comply with workers' compensation laws;

H. Uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

I. Disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

J. Uses and disclosures for other governmental purposes, such as for national security purposes;

K. Uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

L. Uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes

M. Uses and disclosures required by other applicable laws

N. Uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508

O. Enrollment of eligible individuals;

P. Eligibility determinations; and

Q. Payment for coverage;

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions *do not apply* to the following:

A. Disclosures to or request by a health care provider for treatment purposes;

B. Disclosures to the individual who is the subject of the information;

C. Uses or disclosures made based on an authorization requested by the individual;

D. Uses or disclosures required for compliance with HIPAA's transaction standards (see 813);

E. Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; or

F. Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization are exempt.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health information is prohibited in the following situations:

A. *Genetic Information*. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

B. *Employment-Related Actions*. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

C. *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted above, shall not be a permitted use or disclosure.

Plan administration functions do not include functions performed by the Employer for employment-related functions.

The Authorized employees will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of the Plan.

Marketing

The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without the individual's authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product. Specifically excluded from the definition of marketing communications about:

A. Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;

B. Treatment of the individual; and

C. Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about continuation coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance.

It is not marketing for this plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

A. It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to include wellness programs that offer incentives to adopt healthy lifestyle behaviors.

B. It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large.

For marketing activities permitted by an authorization, if there is remuneration, the marketing material must state that the entity making the communication is being paid by another entity.

Underwriting

An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification

In any disclosure other than those allowing the individual to agree or object, verification of the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Legal Control

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. (See statement of ERISA rights.) If there is a discrepancy between the description of the Plan as contained in this material, and the official Plan Document, the language of the Health Expense Reimbursement Option Plan (HERO Plan) Document will apply.

Village of Menomonee Falls
Health Expense Reimbursement Option Plan
(HERO Plan)
Summary Plan Description

Schedule A

Schedule of Benefits

HERO Plan Participants are eligible for 100% reimbursement of in-network out of pocket medical expenses if they waive coverage in the Village of Menomonee Falls medical plan and enroll in their spouse's employer sponsored minimum value plan.

Maximum claim payment is the out-of-pocket maximum of the spouse's employer's HDHC plan, but in no instance will it exceed the limit(s) of the out-of-pocket costs defined in the Affordable Care Act (ACA) for the coverage level enrolled in as adjusted and published annually by the US Department of Health and Human Services (HHS). The limits for the January 1, 2025, thru December 31, 2025, plan year are $9,200 Self-Only and $18,400 for coverage other than self-only coverage.

This is a second submit plan where Explanation of Benefits (EOBs) from the carrier of the spouse's employer's plan must be submitted to claims administrator along with a signed claim form and any other requested documentation. Claims may be submitted by either the employee or the provider. Claim forms must have employee signature.

Employee's and/or spouses and dependents enrolling in the spouse's High-Deductible Health Plan that is an HSA qualified plan have the option to enroll in the HERO Plan Option 1 or HERO Plan Option 2.

- Option 1 – No HSA HERO Plan
    - Deductible, Coinsurance and Copayments are eligible for reimbursement as they are incurred without having to meet a minimum annual deductible.
    - Participants lose eligibility to make or receive any contributions into any HSA Account.
- Option 2 – Post Deductible HERO Plan
    - Eligible expenses must be incurred after the participant meets the HSA statutory Minimum Annual Deductible based on enrollment level. The minimum deductible for the January 1, 2025, thru December 31, 2025, is $1,650 self-only and $3,300 for coverage other than self-only. The Minimum Annual Deductible is adjusted and published annually by the IRS.

Village of Menomonee Falls
Health Expense Reimbursement Option Plan
(HERO Plan)
Summary Plan Description

Schedule A Continued

- Participant will retain eligibility to make contributions to an HSA Account provided they meet all other HSA eligibility requirements. Participant must submit documentation showing that the deductible is met.

Reimbursements are based on the spouse's HDHC Plan's approved amounts that are applied to Deductibles, Coinsurance and Copayments, less any amounts reimbursed by any other accident or health plan.

List of Participating Employers, if any, participating in the plan:

There are no other Employers affiliated with this plan.

Claims can be submitted to the Third-Party Administrator:

44North
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601

Or Faxed to: (855) 306-1098

Village of Menomonee Falls
Health Expense Reimbursement Option Plan
(HERO Plan)
Summary Plan Description

Appendix A

Continuation of Coverage

In General

The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA) unless the employer is exempt.

Continuation of Coverage

To the extent required by COBRA, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Employer elects NOT to allow continuation of any participant upon termination of employment. COBRA continuation may be available for such participant.

Type of Coverage

Continuation coverage under this provision is coverage, which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

You may have other options available when you lose group health coverage

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

Coverage Period

The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event; Note: The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The qualified beneficiary receiving the disability extension is required to notify the Plan Administrator if the SSA makes such a determination, and you must provide this notice within the 30-day period after the SSA makes such a determination. Such a notice is to be in writing and delivered in person or mailed to the Plan Administrator.

C. in the case of a terminated Employee (except for gross misconduct) or covered Employee whose hours have been reduced, and the employee became entitled to Medicare less than 18 months before the qualifying event, for the covered dependents, the date which is 36 months after the date of Medicare entitlement.

D. in the case of a second qualifying event, which includes the death of a covered employee, the divorce of a covered employee and spouse, or a loss of dependent status under the plan, which occurs during the 18-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage). The affected individual is entitled to this continuation coverage period only if it would have caused loss of coverage under the plan, in

the absence of the first qualifying event. The affected individual is required to notify the Plan Administrator in the same manner as Section B Above.

E. in the case of any qualifying event except as described in A., B., and C. above, the date which is 36 months after the date of the qualifying event;

F. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;

G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;

H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). In no event, will coverage continue longer than the coverage period as set forth in this Section.

I. the right of continuation coverage under the Plan may be terminated prior to the end of the continuing coverage period if the individual engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary.

J. the Plan Administrator is required to give notice of Unavailability of Continuation Coverage should the rights of continuation coverage be denied or terminated. This Notice of Unavailability of Continuation Coverage will state the specific reason for denial of the claim for continuation coverage. The individual will be notified of the date the coverage will terminate, and the reason for termination and the rights the qualified beneficiary may have under the plan or applicable law, or to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Contribution

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a participating Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments. The election notice will contain complete information as to the amount of the premium required.

B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

D. Certain individuals may be eligible for a Federal Income tax credit as a result of the Trade Adjustment Assistance Reform Act of 2002 (HCTC). This tax credit helps pay for the premium of continuation coverage. An individual who loses a job due to the effect of international trade may be entitled to this tax credit (payable in some cases directly to the employer to offset the cost of the premium) and qualify for trade adjustment assistance. Those receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) may become entitled to the tax credit as well. If you become entitled to this tax credit, contact HCTC Customer Contact Center at 1-866-628-4282.

Notification by Qualified Beneficiary

Each covered Employee or qualified beneficiary must notify the Employer or a participating Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occur after the date of the enactment of the Tax Reform Act of 1986.

Keep Your Plan Informed of Address Changes. In order to protect you and your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of yourself and/or family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notification Procedure

Any notice that you provide must be in writing addressed to the Plan Administrator. Oral notice, including notice by telephone, is not acceptable. Electronic notices (email or fax) are not acceptable. Your notice must be complete and must be postmarked no later than the last day of the required notice period. Your notice must state the name and address of the Employer, the name of the group health plan, the name and address of the employee covered under the plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

Your notice of a second qualifying event must also name the event and the date it happened.

Your notice of a child's loss of dependent status must include documentation of the date of the qualifying event (i.e., a birth certificate). This will allow the Plan Administrator to

determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.

If the qualifying event or the second qualifying is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability or cessation of disability must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled or ceased to be disabled and the date the Social Security Administration made its determination. Your notice of disability or cessation of disability must include a copy of the Social Security Administration's determination.

Notification to Qualified Beneficiary

A. The Employer or a participating Employer shall provide written notice to each covered Employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

B. The Employer or a Participating Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, Village of Menomonee Falls, shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies Village of Menomonee Falls of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

C. Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

Appendix A Definitions

A. **"Dependent"** means (a) any individual who is a Participant's child as defined by Code §152(f)(1) and who has not attained age 27, and (b) any tax dependent of a Participant as defined in Code §105(b) provided, however, that any child to whom Code §152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

B. "**Election Period**" means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

C. "**Full-Time Student**" means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

D. "**Medicare**" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

E. **"Qualified Beneficiary"** means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term qualified beneficiary includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary.

   Exception - the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

F. **"Qualifying Event"** means with respect to a covered Employee, any of the following events, which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

   i. The death of the covered Employee;

   ii. The termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered employee's employment;

   iii. Divorce or legal separation of the covered Employee from such covered Employee's spouse, as herein defined;

   iv. The covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);

v. A dependent child who ceases to be a dependent child under the terms of this Plan;

vi. The Company's filing for Chapter 11 reorganization as it would affect retiree coverage.

G. **"University/College"** means an accredited institution listed in the current publication of accredited institutions of higher education.