Tentative Agenda
Tuesday, April 21, 2020
6:00 pm

Flandreau School Board
Conference Call

To listen to the board meeting: call 1-312-626-6799
Use the information below when you are prompted:
Meeting ID: 910 1694 7393
Password: 57028

You must enter your first and last name.

I. PLEDGE OF ALLEGIANCE

II. OPEN FORUM*

III. APPROVAL OF AGENDA

IV. COMMUNICATION – Recognition of visitors
a. Superintendent's report.
b. Disclosure/Conflict of Interest.

V. NEW BUSINESS – action items
a. High school remodel project bids.
b. Grab and Go lunches.
c. Renewal of health insurance.
d. Avera Health Service contract.
e. Classified resignation.
f. Executive session – SDCL 1-25-2 (1).
g. New hire
h. Discussion and approval of any action deemed necessary from executive session.
i. Adjournment.

- NOTE: Members of the public who desire to address the board on items of interest or concern that do not appear on the agenda are invited to do so at this time. Up to 15 minutes will be devoted to this agenda item with the board president to increase or decrease the time as needed. It would be most appreciated if you would limit your remarks to not more than 3 minutes; to appoint a spokesperson if the concern is a group concern; and to supplement verbal presentations with written reports, if necessary or desired. We ask that you remember that South Dakota law prohibits the board from discussing specific employees, their job performance, or students. If you have thoughts to share about items that are included as topics for tonight's meeting, we would invite those comments when we reach that point in the meeting.

Avera Health Plans

Avera Benefit Solutions

Group: Flandreau School District

Effective Date of Coverage: 7/1/2020

Contracts Quoted	
Employee	18
Employee + One	3
	0
Family	9
Total	30

2020 South Dakota Large Group Rating | Non-Grandfathered | 3 Tier Level Quote | SIC Code: 8211

Benefit Solutions: Medical & Pharmacy Options

	In-Network		Out-of-Network	
	Individual	Family	Individual	Family
Deductible	$1,000	$2,000	$5,000	$10,000
Coinsurance	$2,000	$4,000	$5,000	$10,000
Coinsurance %	80%	80%	60%	60%
Out of Pocket Maximum	$3,000	$6,000	$10,000	$20,000

In-Network Coverage below. Out-of-Network Coverage is subject to Deductible and Coinsurance		Employee	Employee + One		Family	Total Monthly Premium
Physician Office Visit	Office Visit Co-pay					
	$35 PCP/$35 Specialist					
Pharmacy Benefits:	Pharmacy $12/$35/$50					
90 Days - 3x Copay	No Deductible					
Preventive Benefits	100% Preventive Benefit - NGF					
Chiropractic Office Visit	Co-pay same as PCP Physician Office Visit					
Mental Health Office Visit	Co-pay same as PCP Physician Office Visit					
Emergency Room Option	Deductible/Coinsurance					
Full Time Student Age	Full Time Student thru Age 29					
Out of Network	Option 1 - Standard Out of Network					
Benefit Solutions: Riders						
Vision	VSP - Vision Coverage					
Employee Assistance Program	No Coverage					
Commission Per Employee Per Month:	$15.00					
Total Premium with Commission:		**$498.37**	**$1,034.99**	**$0.00**	**$1,266.49**	**$23,474.03**

Tier Levels	Current Rates	Renewal Rates	% Change
Employee	$474.12	$498.37	5.11%
Emp + 1	$1,000.47	$1,034.99	3.45%
Employee + Children	$0.00	$0.00	0.00%
Family	$1,227.54	$1,266.49	3.17%

PPACA:	NGF
Plan Year:	
PPACA Effective Date:	

Renewal Rates: The above rates are based on the most recent AHP census/claim information. Rates are valid for twelve months from renewal date provided the group renews within 30 days of receipt of this renewal. Renewals not confirmed within 30 days may be re-rated based on updated census and claims information.

Agent Name

Agency Name

Employer Representative Signature

Date

Avera Health Plans

Avera Benefit Solutions

Group: Flandreau School District

Effective Date of Coverage: 7/1/2020

Contracts Quoted	
Employee	27
Employee + One	6
	0
Family	10
Total	43

2020 South Dakota Large Group Rating | Non-Grandfathered | 3 Tier Level Quote | SIC Code: 8211

Benefit Solutions: Medical & Pharmacy Options

	In-Network		Out-of-Network	
	Individual	Family	Individual	Family
Deductible	$2,000	$4,000	$5,000	$10,000
Coinsurance	$2,000	$4,000	$5,000	$10,000
Coinsurance %	80%	80%	60%	60%
Out of Pocket Maximum	$4,000	$8,000	$10,000	$20,000

In-Network Coverage below. Out-of-Network Coverage is subject to Deductible and Coinsurance		Employee	Employee + One		Family	Total Monthly Premium
Physician Office Visit	Office Visit Co-pay					
	$35 PCP/$35 Specialist					
Pharmacy Benefits:	Pharmacy $12/$25/$50					
90 Days - 3x Copay	No Deductible					
Preventive Benefits	100% Preventive Benefit - NGF					
Chiropractic Office Visit	Co-pay same as PCP Physician Office Visit					
Mental Health Office Visit	Co-pay same as PCP Physician Office Visit					
Emergency Room Option	Deductible/Coinsurance					
Full Time Student Age	Full Time Student thru Age 29					
Out of Network	Option 1 - Standard Out of Network					
Benefit Solutions: Riders						
Vision	VSP - Vision Coverage					
Employee Assistance Program	No Coverage					
Commission Per Employee Per Month:	$15.00					
Total Premium with Commission:		**$454.40**	**$942.20**	**$0.00**	**$1,152.65**	**$29,448.48**

Tier Levels	Current Rates	Renewal Rates	% Change
Employee	$431.87	$454.40	5.22%
Emp + 1	$909.79	$942.20	3.56%
Employee + Children	$0.00	$0.00	0.00%
Family	$1,115.99	$1,152.65	3.28%

PPACA:	NGF
Plan Year:	
PPACA Effective Date:	

Renewal Rates: The above rates are based on the most recent AHP census/claim information. Rates are valid for twelve months from renewal date provided the group renews within 30 days of receipt of this renewal. Renewals not confirmed within 30 days may be re-rated based on updated census and claims information.

Agent Name

Agency Name

Employer Representative Signature

Date

Avera Health Plans

For Internal Use Only
Effective Date
Group Number

Employer Participation Agreement

Please select one: ☐New Group OR ☐Renewal Group

Group Type: ☐ Large Employer Non-Grandfathered ☐ Large Employer Grandfathered
☐ Small Employer Transitional ☐ Small Employer Grandfathered

EMPLOYER INFORMATION

Legal Name of Employer _____ President/CEO _____

Employer Contact Name _____ Phone (____) _____ — _____ Ext _____

Email _____ Fax (____) _____ — _____

Street Address _____ City _____

County _____ State _____ ZIP _____

Mailing Address _____ City _____ State _____ ZIP _____
(If different than Street Address)

Tax Identification Number (TIN) _____ SIC Code _____

Legal Status: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Government Entity ☐ LLC ☐ Other, Explain _____

Does your business have more than one location? ☐Yes, list all locations to be covered under this plan ☐ No

Location Address	City	State	ZIP	Number of Employees

(If necessary, attach separate location listing.)

Are any associated business organizations to be covered? (Parent subsidiary, brother-sister relationships, affiliated groups)
☐ Yes ☐ No, If yes complete the following:

Name	Address	Nature of Business	Business Relationship	Number of Employees

(If necessary, attach separate listing.)

ELIGIBILITY

1. In the past 12 months, have any employees not worked full-time due to injury, illness or disability? ☐ Yes ☐ No
2. Are retirees eligible for coverage? ☐ Yes ☐ No If yes, please attach copy of your retiree policy
3. Number of current employees: Full-time: _____ Part-time/Seasonal: _____Total Employees: _____
4. Number of employees who have worked at least 50% of the working days in the preceding calendar year: _____
5. Of the total number of current eligible employees applying for medical coverage:
   a. Number applying for employee coverage only: _____
   b. Number applying for dependent coverage: _____
   c. Number of applicants on COBRA/State Continuation: _____ Applicants name(s): _____
   NOTE: Documentation for all COBRA/ State Continuation participants required for new large employer non-grandfathered groups.
   d. Number of hours worked per week to be eligible: _____
   e. Is plan management only? ☐ Yes ☐ No
6. Does your company have a Medical Leave of Absence (LOA) policy? Yes ☐ No ☐ If yes, please attach a copy.
   NOTE: LOA greater than 12 weeks may affect rates.

7. Does your company have a layoff policy? ☐ Yes ☐ No If yes, please attach a copy.
8. Waiting Period. Future employees become eligible for insurance, choose one:

☐ 1st day of the month following 30 days ☐ 1st day of the month following 60 days ☐ 90 days

☐ Other: _____

PLAN INFORMATION

Requested Effective Date: _____ The employer acknowledges that the Requested Effective Date is the group's Plan Year, unless the employer designates a different plan year in a written plan document. The employer agrees to provide Avera Health Plans with a copy of any such written plan document that is in existence. Coverage is not effective until notified in writing.

Defined Contribution Plan: ☐ Yes ☐ No

Premium Only Plans Accounts: Please check services you would like Avera Health Plans to administer;

Premium Only Plans (If yes, additional paperwork required) $100.00 annually

- Medical ☐ Yes ☐ No
- Dental ☐ Yes ☐ No
- Other ☐ Yes ☐ No

Selection of the following will require additional paperwork:

FLEX: ☐ Yes ☐ No

$4.85 PPPM plus $250 initial set-up fee and $150 annual renewal fee*

Health Savings Account (HSA): ☐ Yes ☐ No

$3.25 PPPM plus $250 initial set-up fee and $150 annual renewal fee*

COBRA/State Continuation of Coverage Administration Services: ☐ Yes ☐ No

If no, please provider name of Coverage Administrator _____ Phone (____) _____ — _____

Note: No additional cost to the employer for Avera Health Plans Cobra Services.

*If group opts for both Flex and HSA Administration, only one initial set-up fee and one annual renewal fee is owed.

1. Deductible: ☐ Calendar Year Deductible ☐ Contract Year Deductible ☐ Other, explain: _____
2. Open Enrollment Offered? ☐ Yes ☐ No

   If yes, check one: ☐ On Renewal Date or ☐ Calendar Year

   (The 30-day Open Enrollment Period begins 45 days prior to and then ends 15 days prior to the Open Enrollment Effective Date unless otherwise agreed upon with Avera Health Plans.)
3. Employer contribution to the premium as of the requested effective date: Employee: ____% Dependent: ____%
4. Employer contribution to the premium on March 23, 2010: Employee: ____% Dependent: ____%
5. Will this plan replace other group coverage? ☐ Yes ☐ No

   If yes, complete the following and attach a copy of the most recent billing.

   Prior Coverage Effective Date: _____ Prior Coverage Termination Date: _____
6. Previous Insurance Carrier _____ Phone (____) _____ — _____
7. Worker's Compensation Carrier _____ Phone (____) _____ — _____

AGENT STATEMENT

I certify that to the best of my knowledge, all of the information contained in the Employer Participation Agreement and any attached documents are correct.

Agent's Signature _____ Agent TIN _____ Date _____

Agent Name (please print) _____ Phone (____) _____ — _____

Agency Name _____ Fax (____) _____ — _____

Address _____ City _____ State ____ ZIP _____

EMPLOYER PARTICIPATION AGREEMENT

The employer hereby applies for or renews group health coverage provided by Avera Health Plans and agrees to be bound by all terms and conditions of the Certificate of Coverage issued to the employer. If your group is subject to ERISA, the Certificate of Coverage is not intended to serve as the ERISA plan document of summary plan description which the employer must provide. The employer acknowledges that the Certificate of Coverage is available for inspection by any person covered by the Certificate of Coverage by contacting us. The employer represents that the information provided on this Employer Participation Agreement is complete and true to the best of its knowledge and belief. The employer understands that no insurance will become effective without the written approval of Avera Health Plans and that any fraud or intentional misrepresentation may nullify coverage for employees and dependents. Employer understands that the rates quoted were based on census information and data provided by the employer. Should the enrolled group's data provided by the employer vary by more than 10%, we reserve the right to adjust the rates to reflect the enrolled group's actual data. Rates are valid from effective date, provided the group enrolls on the date quoted, but not later than the first of the following month. Rates are subject to approval by the state agency responsible for the regulation of insurance products.

It is further understood that no agent has the authority to alter or amend the Certificate of Coverage or to bind Avera Health Plans by making any promise or representation. We will share with the agent of record the quarterly and/or annual claims reports, unpaid premium notices, and renewal rates.

It is further understood and agreed that benefits under the Certificate of Coverage and the cost of providing those benefits may change. No insurance coverage will become effective until the first full premium has been paid. The employer must provide a completed EFT form or pay 100% of the first month premium (binder payment) in full no later than 30 days from the effectuation date or they will be terminated as never effective. Premiums are due and payable on or before the first day of the month of service. Avera Health Plans will allow a 30-day grace period to the employer for receipt of the premiums. Coverage shall be provided under the Certificate of Coverage during the 30-day grace period as long as the outstanding premium is paid within the grace period. We may suspend the processing of the group's medical and pharmacy claims for services received during the grace period if your premium is not been paid by the due date. Failure to pay the outstanding premium within the 30-day grace period will cause the Certificate of Coverage to be terminated retroactive to the last day of the month for which payment has been received.

The employer is responsible for auditing its monthly premium invoice. The employer shall notify Avera Health Plans by completing the Termination of Coverage Form whenever any member ceases to be eligible for coverage, as soon as possible, no later than 30 days after the event that rendered the member ineligible for coverage. The member will be termed for coverage at the end of the termination month and premiums must be paid in full for that member. The employer will be liable to pay the premium on behalf of any member for whom the required notice of ineligibility has not been given and will be required to pay for any charges incurred during the time a person was not an eligible member. If the employer has a covered employee (person who works at least 30 hours per work week) on any form of leave of absence that exceeds 12 weeks in length, the employer agrees to notify us of such employee's status as soon as reasonably possible, and in no event later than 30 days after the leave ends. We will not provide coverage for members of the employer who are on leave of absence for more than 12 weeks per year unless the extended leave of absence policy is provided with this Agreement. If the employer wishes to have employees remain on leave of absence and still be covered by Avera Health Plans, the employer's premium must be underwritten accordingly to conform with the employer's request.

The employer must provide Avera Health Plans with the information needed to administer the Certificate of Coverage and to compute the premium due. Failure of the employer to provide this information will not void or discontinue a member's coverage. The employer has the right to examine our records on the services provided at any reasonable time while this Certificate of Coverage is in force. Avera Health Plans also has this right until all rights and obligations under the Certificate of Coverage are finally terminated.

The plan may terminate or not renew the Certificate of Coverage if one of the following circumstances occurs:

(a) the employer has failed to pay any premium or contributions in accordance with the terms of the Certificate of Coverage or has not made timely premium payments;
(b) the employer performs an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact;
(c) the employer has failed to comply with a material Certificate of Coverage provision relating to employer contribution or participation rules;
(d) Avera Health Plans discontinues its offering of the type of group health insurance offered; or
(e) there is no longer any eligible group participant or member in connection with the Certificate of Coverage who lives or works in the plan's service area.

Any person who, with the requisite intent to defraud or knowing that they are facilitating a fraud against Avera Health Plans in submitting an application or claim combining a false or deceptive statement may be guilty of insurance fraud as specified in applicable state law.

Employer agrees to use any of Avera Health Plans' supplied forms for purposes of performing duties under this agreement. This provision does not, however, require that we create and/or supply forms to group for COBRA/Continuation of Coverage administration.

Upon Avera Health Plans' signature, Avera Health Plans agrees to provide coverage to employer as defined in this agreement.

Authorized Employer Signature _____ Title _____

Print Name _____ Date _____

Avera Health Plans _____ Date _____
Chief Executive Officer

Print Name _____

Avera Health Plans
5300 S. Broadband Ln. • Sioux Falls, SD 57108-2221 • Phone 605-322-4545 • AveraHealthPlans.com

COBRA/CONTINUATION OF COVERAGE

ADMINISTRATIVE SERVICES AGREEMENT

This COBRA/Continuation of Coverage Administrative Service Agreement ("Agreement") is made and entered into this _____ day of _____, 20___, between Avera Health Plans, Inc., a South Dakota corporation located at 3816 S. Elmwood Avenue, Sioux Falls, SD 57105 ("Avera Health Plans"), and _____ ("Employer").

WHEREAS, Avera Health Plans provides group health insurance and third party benefit administration services; and

WHEREAS, the Employer offers an employee welfare benefit plan or plans for its employees; and

WHEREAS, Avera Health Plans and the Employer mutually desire that Avera Health Plans will provide administrative services for the purpose of the benefits continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or applicable state continuation of coverage requirements to the employees of the Employer in accordance with the terms and conditions of this Agreement.

Now therefore, in consideration of the mutual covenants contained herein, the parties agree as follows:

Section 1. PURPOSE. This is an agreement between the parties relating to the provision of COBRA and applicable state continuation administrative services to the Employer. Pursuant to the terms of this Agreement, Avera Health Plans shall provide documents to Employer which will enable the Employer to initiate services. Services shall, however, only be provided by Avera Health Plans to the Employer upon a specific request for the services by the Employer. Employer must indicate on the Participation Agreement its intention to receive COBRA/Continuation of Coverage Administration Services in order for services to begin. The services provided shall include compliance with the COBRA/Continuation of Coverage requirements and will also include the administration of these requirements for applicable employee benefit plans of the Employer.

Section 2. DEFINITIONS. Whenever used in this Agreement, the following terms have the respective meanings set forth below, unless the context clearly requires otherwise, and when the defined meaning is intended, the term is capitalized:

Section 2.1 Contract Year shall mean the twelve-month period beginning on the date the agreement is to go into effect.

Section 2.2 Plan shall mean the employee benefit plans of an Employer to which COBRA/Continuation of Coverage laws apply.
Section 2.3 Employer shall mean the employer or association of employers who request that Avera Health Plans provide services to it under this Agreement.
Section 2.4 Plan Sponsor shall mean an employer or employer-designated entity that is responsible for the establishment and maintenance of the Plan.
Section 2.5 Qualified Beneficiary shall have the meaning attributed to that term under the Consolidated Omnibus Budget Reconciliation Act of 1985 or applicable state law regarding continuation of coverage benefits.
Section 2.6 Qualifying Event shall have the meaning attributed to that term under the Consolidated Omnibus Budget Reconciliation Act of 1985 or applicable state law regarding continuation of coverage benefits.

Section 3. DUTIES OF AVERA HEALTH PLANS.

Section 3.1 COBRA/Continuation of Coverage Administration. With respect to every Plan, Avera Health Plans shall administer the applicable continuation of benefits requirements of COBRA or State Continuation of Coverage regulations. Avera Health Plans shall provide such services in a manner which complies with the requirements of applicable benefits continuation laws. Avera Health Plans shall not, for any purpose, be deemed to be a "Fiduciary" (as defined in ERISA or the Internal Revenue Code) of the Plan or the sponsor of the Plan. The sole function of Avera Health Plans is to provide administration services and Employer agrees that Avera Health Plans shall have no liability for the funding of participant premiums. Specifically, Avera Health Plans shall provide the following services with respect to each Plan according to applicable law:

3.1.1 General COBRA Notification. Employer shall be responsible for providing the COBRA General Notice to inform newly hired employee(s) of their rights under COBRA;
3.1.2 Election Notices. When a qualifying event occurs and Avera Health Plans is informed, Avera Health Plans shall advise qualified beneficiaries in writing of their rights under current laws and regulations relative to continued coverage under the Employer's group health plan(s);
3.1.3 Initial Election Period. Avera Health Plans shall track the time frame described by applicable law within which a Qualified Beneficiary must elect continuation coverage;
3.1.4 Payment Coupons. Avera Health Plans shall issue payment coupons and instructions for making the required premium payments and maintaining coverage, for every Qualified Beneficiary who elects the continuation of coverage under applicable law within the prescribed time frame;
3.1.5 Premium Collection. Avera Health Plans shall receive, account for, and appropriately distribute the payments received from the Qualified Beneficiary. In the event that incomplete or incorrect remittances are submitted to Avera Health Plans, Avera Health Plans shall contact the Qualified Beneficiary in an effort to correct any error in the remittance;
3.1.6 Forms. Avera Health Plans shall provide Employer with forms to be used to notify Avera Health Plans of Qualifying Events;
3.1.7 Rate Change Notices. Avera Health Plans shall notify Qualified

Beneficiaries of any changes advised by the Employers or health care reimbursement entities to the amount of the premium which the Qualified Beneficiaries must pay in order to maintain their coverage under a Plan;
3.1.8 Open Enrollment Notices. Employer shall notify Qualified Beneficiaries as required in the event that their continuation options are modified as a result of an open enrollment process of an Employer;
3.1.9 Intent to Cancel Notices. In the event that a Qualified Beneficiary fails to remit a required premium payment by its due date, Avera Health Plans shall notify the Qualified Beneficiary of his or her failure to remit, the consequences of such failure, and the final date by which payment must be received in order to continue his or her COBRA coverage;
3.1.10 Service Telephone Line. Avera Health Plans shall maintain a telephone number and a staff of service representatives to assist Employers and Qualified Beneficiaries in determining their responsibilities, rights, and current status under applicable law.

Section 3.2 Continuation Information and Administrative Forms. Avera Health Plans shall prepare, and distribute such information materials as are considered by it to be necessary in order to describe to Employers and Qualified Beneficiaries their rights and obligations under COBRA/Continuation of Coverage. Avera Health Plans shall also prepare such notices and administration forms as are necessary to comply with the requirements of COBRA/Continuation of Coverage and applicable state law.

Section 3.3 Reports and Records.

3.3.1 Notification/Continuation Records. For each Employer and for each Qualified Beneficiary, Avera Health Plans shall maintain records of notifications sent, continuation elections made, and premiums received.
3.3.2 Financial Reports. Avera Health Plans shall prepare for each Employer and submit as necessary or requested, year-to-date financial information for the Employer's use in preparation of any and all reports required by the Internal Revenue Service, the Department of Labor and any other Federal or State agencies.

Section 4. DUTIES OF EMPLOYER.

Section 4.1 Eligibility and Providing Information.

4.1.1 The Employer shall advise Avera Health Plans of the following events within thirty (30) days of the qualifying event date or the last date of coverage, whichever is later, of said event(s):
(a) Death of a covered employee;
(b) Termination of a covered employee (for reasons other than gross misconduct) or reduction in the employee's hours;
1)The Employer shall be solely responsible for determining whether or not the employee has been terminated for gross misconduct, as that term is defined by COBRA or applicable state continuation of coverage requirements;
(c) Covered employee becoming entitled to benefits under Title XVIII of

the Social Security Act (Medicare);

4.1.2 The employee is responsible for providing notice to the Employer within 60 days of the following events:

(a) Divorce/legal separation of covered employee;

(b) Dependent children who cease to be covered as a "dependent" under the terms of the group health plan(s);

4.1.3 Eligibility Determinations. Upon request for services under this Agreement by an Employer, the Employer shall immediately notify Avera Health Plans using the applicable form of all persons entitled to continuation coverage under applicable law, including in its notification information with respect to persons currently continuing coverage under the Plan to allow Avera Health Plans to assume responsibility for the future administration of the continuation of said coverage. To the extent that the Employer fails to provide accurate information concerning or to notify Avera Health Plans using the applicable form of the existence of persons currently continuing coverage or of new Qualified Beneficiaries, or in the event that the Employer does not provide adequate notification, Avera Health Plans shall not be responsible for the failure by the Employer to notify Avera Health Plans.

4.1.4 Failure to Provide Information. In the event the Employer fails to provide Avera Health Plans with accurate information required for Avera Health Plans to provide the services to be rendered herein, on a timely basis, the Employer agrees to indemnify, hold harmless, and defend Avera Health Plans from and against any and all liabilities, losses, damages, claims, lawsuits, causes of action, costs and expenses that may be incurred by Avera Health Plans in connection with the failure of the Employer to provide Avera Health Plans with accurate information on a timely basis necessary to carry out its obligations under this Agreement, provided that Avera Health Plans' action or failure to act in response to such lack of notice was not malicious or grossly negligent. The Employer further agrees to inform Avera Health Plans of any changes to the benefit plan at any time to ensure proper billing.

Section 5. FEES.

Section 5.1 Compensation. To compensate Avera Health Plans for providing its services hereunder, the Employer agrees to pay to Avera Health Plans the following amount: $ No Fee.

5.1.1 Additional Fees. Fees for services rendered by Avera Health Plans in connection with arbitration or litigation concerning the continuation of benefits under a Plan shall be paid to Avera Health Plans by the Employer pursuant to a separate written agreement between the Employer and Avera Health Plans. Unless the parties enter into such an agreement, Avera Health Plans is not required to provide any services to a Employer in connection with the arbitration or litigation.

Section 6. ADMINISTRATION RECORDS. Avera Health Plans agrees that all forms, lists of names, journals, ledgers, and other records incidental to the administration of this Agreement shall remain the property of the Employer to whom services have been provided by Avera Health Plans. As such, in the event of the termination of this Agreement or the termination of services to an Employer under this Agreement all such records shall be returned to the Employer. Avera Health Plans shall have the right to retain copies of such property and records as it deems necessary.

Section 7. DURATION AND TERMINATION.

Section 7.1 Term. This Agreement shall become effective as of the date stated in the opening paragraph and shall continue in full force and effect for a twelve (12)-month period. Thereafter, except as provided in Section 8, this Agreement shall automatically renew for additional and successive twelve-month terms unless either party gives at least thirty (30) days advance written notice by certified mail to the other party of its intent to terminate this Agreement on the anniversary date next following delivery of such notice.

Section 7.2 Termination. Either party may terminate this Agreement immediately upon written notice in the event of (a) the bankruptcy, insolvency or liquidation of the other party; (b) the commission by the other party of any breach of this Agreement or any act of fraud, willful misconduct or bad faith in connection with the performance of its duties under this Agreement with Avera Health Plans; (c) upon the effective date of the cancellation of the Employer's Administrative Services Only agreement with Avera Health Plans Benefit Administrators; or (d) upon the effective date of the cancellation of the Employer's Participation Agreement.

Section 7.3 Employer hereby agrees that all administrative procedure manuals, data processing systems, computer programs, notice forms, and election forms are the sole property of Avera Health Plans and that Employer shall have no right to use these materials following the termination of this Agreement.

Section 8. GENERAL PROVISION.

Section 8.1 Arbitration. In the event of any dispute under this Agreement, the parties agree to binding arbitration in Minnehaha County, South Dakota, in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with discovery being governed by the Federal Rules of Civil Procedure. Each party will name one arbitrator, and the arbitrators so chosen will name a third neutral arbitrator. Judgment upon the award rendered by the arbitrators may be entered into the judgment docket of any court having jurisdiction thereof. The parties to it shall share the cost of arbitration equally. Each party shall be solely responsible for its attorneys' fees, if any. The obligation set forth in this section shall survive the termination of this Agreement.

Section 8.2 Assignment. This Agreement may not be assigned by either party without the written consent of the other party.

Section 8.3 Governing Law. This Agreement shall be construed consistent with federal law and state law including applicable provisions of the Internal Revenue Code and the regulations of the United States Departments of Labor and Treasury. Subject to the foregoing, questions of construction and interpretation of this Agreement shall be governed by the laws of the State of South Dakota.

Section 8.4 Entire Agreement. This Agreement contains the entire agreement and understanding of the parties with respect to its subject matter and supersedes all prior agreements, representations and understandings between any of the parties hereto with respect to the subject matter of this Agreement.

Section 8.5 Severability. If any provisions of this Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality or enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

In witness whereof the parties hereto have caused the execution of this Agreement the day and year first above written.

EMPLOYER	AVERA HEALTH PLANS, INC.
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

DAS
DAKOTACARE ADMINISTRATIVE SERVICES, INC.

Premium-Only Plan (POP)
Employer Setup Request

What is a Premium-Only Plan?
A Premium-Only Plan is a pre-tax salary reduction plan that allows employees to pay group insurance premiums. If you have a Premium-Only Plan, you are required to have a plan document to keep on record and a Summary Plan Description to distribute to employees. You must also keep a record that the employee has agreed to let you reduce their payroll.

These plans are for employers who do not want to offer a full Flexible Spending Account Plan, but still want to offer a tax benefit for their eligible employees.

What premiums qualify? Please select plans offered:

☐ Group Health Insurance
☐ Employee Group Term Life Insurance
☐ Cancer Insurance
☐ Medicare Supplemental Insurance
☐ Vision Insurance
☐ Prescription Insurance
☐ Health Savings Account contributions
☐ FSA Contributions
☐ Disability Insurance
☐ Accident Insurance
☐ Dental Insurance

Employee benefits:
- Reduce income taxes (Federal, State, and FICA): pre-tax payroll deductions result in a lower taxable salary.
- Under a Section 125 Premium-Only Plan, employee's take-home pay is increased which helps reduce the high cost of providing health coverage for family members.

Employer benefits:
- Reduce payroll taxes (including Social Security and Medicare): for every dollar of employee contribution into the Premium-Only Plan.
- Save on the cost of administration: the tax savings gained often covers the entire cost of plan administration.

Who can participate in a Premium-Only Plan?
Employees of regular corporations, S corporations, limited liability companies (LLCs), partnerships, sole proprietors, professional corporations, and non-profit organizations can all reduce payroll taxes by establishing a Section 125 Premium-Only Plan.

Complete the following to set-up a Premium-Only Plan

1. **Plan:**
   ☐ New Plan Effective Date _____ ☐ Amended Plan Effective Date _____
   ☐ Initial Plan Effective Date _____ ☐ Short Plan Year

2. **Employer Information:**
   Employer Name _____ Contact Name _____
   Contact Email _____
   Address _____
   City _____ State _____ ZIP _____
   Phone _____ Fax _____ Federal Tax ID _____

3. **Type of Company:**
   ☐ C Corporation ☐ S Corporation ☐ LLC ☐ Partnership ☐ Proprietorship ☐ Tax-Exempt ☐ Other

4. **List any subsidiary/affiliate to be included in the plan** (Include a separate sheet if you have additional information.)

Name _____ Federal Tax ID _____

Address _____

City _____ State _____ ZIP _____

5. **Employee Information**

A. Number of Eligible Employees: _____

B. Eligibility Conditions (Check All That Apply)

- ☐ Same as employer group's health insurance plan
- ☐ Date of hire
- ☐ _____ Days after date of hire
- ☐ _____ Months after date of hire
- ☐ Other _____

C. Employee Eligibility (Check One)

- ☐ All employees who satisfy eligibility requirements
- ☐ Salaried Employees Only
- ☐ Hourly Employees Only
- ☐ All Employees Except:
  - ☐ Employees not eligible for group health insurance plan
  - ☐ Employees who work less than _____ hours per week/year
- ☐ Other _____

D. Plan Entry Date (Check One)

- ☐ Same as employer group's health insurance plan
- ☐ First day of the pay period following the date the requirements were met
- ☐ First day of the month following the date the requirements were met
- ☐ First day of the plan year following the date the requirements were met
- ☐ Date conditions of eligibility were met

E. Employee Elections

- ☐ No election required, may opt-out
- ☐ Election requested 1st year only
- ☐ Election requested every year

F. Include Participant Election Forms

- ☐ Yes
- ☐ No

6. Agreement

I certify that I am legally authorized to sign this set-up document on behalf of the employer named herein. The employer hereby agrees to purchase those services indicated on this agreement at the cost provided in the flexible benefits proposal or fee schedule.

Printed Name	Signature
Title	Date
Submitting Agent Printed Name	Signature
Company/Agency	Date

You will be charged a $100 Document Creation Fee if enrolled in medical coverage through Avera Health Plans. For all clients that do not have insurance through Avera Health Plans or DAKOTACARE the fee is $200. You may have to pay an additional fee if regulatory updates require a new plan document to be created.

DASFLEX 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Toll-Free: 1-888-322-2115
Email: dasflex@averahealthplans.com

CONTRACT FOR PROVIDING SCHOOL HEALTH SERVICES
BETWEEN

Flandreau Public School District 50-3 600 Community Drive Flandreau, SD 57028	Avera McKennan d/b/a Avera Flandreau Hospital 214 N. Prairie St. Flandreau, SD 57028
Referred to as "School"	Referred to as "Provider"

The Provider hereby executes an agreement for providing school health services to the School.

I. THE PROVIDER

A. The Provider's services on this agreement shall begin on July 1, 2020, and end June 30, 2021. The Provider will not pay for any services provided by the Consultant unless this contract is signed by all parties BEFORE THE CONSULTANT BEGINS TO PROVIDE SERVICES.

B. The Provider agrees to provide 230 hours (of which includes time spent traveling) of basic school health services listed below, as requested by the School at the rate of $25.46 per hour:

i. PREVENTION CARE FOR CHILDREN

a. Complete health assessments in grades pre-kindergarten or kindergarten, 5th grade (Recommended for pre-kindergarten, kindergarten, fifth grade) and any school child on referral.
b. Scoliosis screening to girls (Recommended for the fifth and seventh grade) in grades 5th and 7th grade and boys (Recommended for the ninth grade) in 9th grade and any school child on referral.
c. Vision screening for grades pre-kindergarten, 1st, 3rd, 5th, 7th, 8th, and 10th grades and any school child on referral.
d. Hearing screening for pre-kindergarten, 5th grade, and any school child on referral.
e. Developmental screening in pre-kindergarten and any school child on referral.

ii. STUDENT EDUCATION

a. Provide student education in some or all of the following areas:
   - STD education
   - Growth and Development: Puberty changes, Menstruation, Breast and Testicular Self-exam
   - Oral Health
   - Nutrition: Sports Nutrition, Fruits and Veggies-More Matter, Think Your Drink
   - Hygiene: Hand washing
   - Injury Prevention: Farm Safety, Seatbelt, Suicide
   - Tobacco and Substance Abuse

C. The Provider agrees to provide school health services listed below, as requested by the School at the rate of $42.44 per hour. These services are paid 100% by the School, as Public Health Alliance contract does not pay for any of these services:

i. Assessment of individuals and groups of school children for head lice infestations.

ii. The Provider agrees to supervise and monitor the school district's medication distribution policies and procedures.

iii. Crisis Prevention and Education

iv. Employee Education
   1. Educational sessions regarding specific disease/process (i.e. diabetes, allergic reactions, seizures etc.)
   2. Training for unlicensed assistive personnel for the South Dakota's Board of Nursing (SDBON) Unlicensed Diabetes Aide registry

v. Diabetes services:

   1. Provider's nurse will be available to oversee and implement needed interventions for diabetic students as directed on each students individualized medical management plan as ordered by his/her medical provider. On days that the provider's nurse is unavailable the school will provide appropriately trained personnel listed on the South Dakota's Board of Nursing (SDBON) Unlicensed Diabetes Aide Registry or have an appropriate parent or guardian provide the needed care. The Provider's nurse will delegate insulin administration when he or she is not physically present on site to administer the insulin. A nurse will be available via electronic communication for all mealtimes. An exact schedule can be determined between School Principal and Provider. Changes to the schedule needed by Provider and or School will be communicated via telephone.

   2. The time Provider spends providing services will be charged against total hours of services provided to the School.

D. The provision of the services described in this Agreement is contingent on the Provider having sufficient staff to provide the services. In the event the Provider does not have sufficient staff to provide the services, the Provider will be able to discontinue services without penalty.

II. THE SCHOOL

A. The School agrees to provide clerical support as needed to provide services (such as assistance in directing students to screenings).

B. The School agrees to provide space appropriate for services provided (including space that allows privacy for scoliosis screening and health assessments, quiet area for hearing screenings, etc.)

C. The School agrees to distribute information to parents regarding services provided.

D. The School agrees to hold harmless and indemnify the Provider, its officers, agents and employees, from and against any and all actions, suits, damages, liability or other proceedings which may arise as a result of

performing services hereunder. This section does not require the School to be responsible for or defend against claims or damages arising solely from acts or omissions of the Provider, its officers or employees.

III. OTHER PROVISIONS

A. INTEGRATION/CHOICE OF LAW AND FORUM PROVISION: This contract contains the entire agreement between the parties, and may be amended only in writing signed by both parties. Each amendment shall be attached to and become a part of this contract. The terms and condition of this contract are subject and will be construed under the laws of the State of South Dakota. The parties further agree that any dispute arising from the terms and conditions of this contract, which cannot be resolved by mutual agreement, will be tried in Hughes County, South Dakota.

B. TERMINATION PROVISION: This contract can be terminated upon thirty (30) days written notice being received by the other party and may be terminated for cause by the Provider at any time with or without notice.

C. FUNDING TERMINATION: This contract depends upon the continued availability of appropriated funds and expenditure authority from Congress, the South Dakota Legislature or the South Dakota Executive Branch for this purpose. This contract will be terminated for cause by the School if Congress, the Legislature or the Executive Branch fails to appropriate funds, terminates funding or refuses to grant expenditure authority. Funding termination is not a default by the School nor does it give rise to a claim against the School.

D. NONASSIGNMENT PROVISION: This contract may not be assigned by either party without the written consent of the other.

E. AMERICANS WITH DISABILITIES ACT PROVISION: The School agrees to provide all services required in this contract in compliance with the Americans with Disabilities Act (ADA) OF 1990, 42 U.S.C. # 12101-12213, and any amendments thereto.

F. SMOKE FREE WORK PLACE: To promote a safe and healthy working environment for all people, the Provider strongly encourages the School to provide a smoke free work place in any buildings where services pursuant to this contract are rendered.

G. DRUG FREE WORK PLACE: To promote health and safety, the School agrees to encourage all its employees to refrain from using illegal drugs which may affect an employee's ability to perform the essential functions required under the terms and conditions of this contract. The Provider reserves the right to terminate this contract if the School, or any of its employees or agents, is convicted of using illegal drugs.

H. RECYCLING: To help preserve our natural resources and reduce the need for additional landfill space, the Provider strongly encourages the School to establish a recycling program, to promote the separation and recovery of recyclable materials, and to transport those recyclable materials to the nearest recycling center.

I. CIVIL RIGHTS POLICY PROVISION: Both parties agree to provide services covered by this contract without regard to race, color, sex, religion, national origin, creed, marital status, age or disability as prohibited by state or federal law.

J. AUDIT REQUIREMENTS PROVISION: Governmental sub-recipients are required to have audits performed in accordance with the Single Audit Act of 1984 and Office of Management and Budget Circular A-128, Audits of State and Local Governments. The School agrees to ensure that a copy of the final audit report is provided to the Department of Health Finance Office within thirty days upon receipt of the audit results. All audits may be conducted by an auditor approved by the Auditor General to perform the audit. Approval may be obtained by forwarding a copy of the audit engagement letter to the Department of Legislative Audit, 427 South Chapelle, c/o 500 East Capitol, Pierre, SD 57501-5070.

K. PERSONNEL PROVISION: Neither the School nor any employees or agent thereof will hold him or herself out as or claim to be an officer or employee of the Provider and will not make any claim, demand or application to or for any right or privilege applicable to an office or employee of the Provider including, but not limited to workers' compensation, health, life or malpractice insurance, retirement membership or credit, and the School agrees to assume responsibility for such liabilities.

L. CONTRACT ORIGINAL AND COPIES: An original of this contract will be retained by the Provider. A second original will be sent to the School.

M. RECORD RETENTION/EXAMINATION: The School agrees to maintain all records that are pertinent to this contract and retain them for a period of three years following final payment against the contract. The Provider agrees to assume responsibility for these items after that time period. These records shall be subject at all reasonable times for inspection, review or audit by the State, other personnel duly authorized by the State, and federal officials so authorized by law.

The parties signify their agreement by signing below.

Mr. David Flicek, President and CEO Avera McKennan d/b/a Avera Flandreau Hospital	President, School Board
Date	Date
	School Superintendent
	Date