

This document is a Plan Document and a Summary Plan Description. When accompanied by the appropriate Certificates of Coverage, this document, along with those Certificates, becomes the Summary Plan Description. When accompanied by the appropriate Insurance Contracts, this document, along with those Contracts, becomes the Plan Document.

On September 2, 1974, the Employee Retirement Income Security Act of 1974 (often referred to as ERISA) was enacted, establishing Federal controls over most employee welfare benefit plans. The plans identified on the following pages are subject to regulation by ERISA. All plans outlined have the following ERISA specifications in common:

Section 1: General Plan Information

Plan Name:

Plan Number:

**Employer/Plan Sponsor
Name, Address and
Phone Number:**

Employer ID #:

Plan Year:

Plan Administrator The Plan Administrator has authority to control and manage the operation and administration of the Plan, and complete discretion to interpret Plan terms.

**Agent for Service
of Legal Process:**

**Plan Changes or
Termination:** The Plan Administrator may terminate, suspend, withdraw, amend or modify any Plan in whole or in part at any time, with or without notice, subject to the applicable provisions of the group benefit policies or Employer policies as outlined in the contracts, Employer minutes and/or bylaws.

**Accompanying
Documents:** **SPD** – In the case of an insured benefit, the term “Certificate of Coverage” refers to Plan documentation provided by the issuing insurer, which describes the plan benefits in detail. Certificates of Coverage are sometimes also referred to as Certificates, Evidence of

Coverage, Plan Booklets, etc. by the insurer that issues them. If you do not have a copy of your Certificate of Coverage, you may obtain one from the Plan Administrator.

Plan Document – In the case of an insured benefit, the term “Insurance Contract” refers to Plan documentation provided by the issuing insurer, which outlines the important elements of the agreements/contracts between the Employer/Plan Sponsor and the insurer. Insurance Contracts are sometimes also referred to as Insurance Policies, Contracts/Policies, or Service Agreements by the issuing insurer.

Employee:

The term “Employee” means a common law employee of the Employer who otherwise meets eligibility criteria for each type of Plan benefit. The term “Employee” excludes individuals classified by the Employer as independent contractors, leased or agency employees (or the equivalent), regardless of whether or not such individuals are in fact common law employees of the Employer for tax or other purposes.

The following pages outline those plan specifications that vary between the different programs established as part of the [Insert Plan Name].

Section 2: Benefit Information (Fully Insured Benefits)

Plan Number:	
Policy Number:	
Type of Plan Benefit:	
Type of Plan Administration:	
Contract Administrator: <i>Responsible for plan administration and processing of claims.</i>	
Insurer: <i>Responsible for payment of claims and for financial risk of claims.</i>	
Funding Arrangement:	Benefits are provided through purchase of an insurance contract with an insurer, which is solely responsible for payment of benefits and final determinations of benefit eligibility.
Eligible Employees and Eligibility Criteria:	
Plan Premiums/Contributions:	
Special Notes:	

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and an insurance company. If the terms of this summary document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superceded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 2: Benefit Information (Fully Insured Benefits)

Plan Number:	
Policy Number:	
Type of Plan Benefit:	
Type of Plan Administration:	
Contract Administrator: <i>Responsible for plan administration and processing of claims.</i>	
Insurer: <i>Responsible for payment of claims and for financial risk of claims.</i>	
Funding Arrangement:	Benefits are provided through purchase of an insurance contract with an insurer, which is solely responsible for payment of benefits and final determinations of benefit eligibility.
Eligible Employees and Eligibility Criteria:	
Plan Premiums/Contributions:	
Special Notes:	

The benefits identified above are provided pursuant to Insurance Contracts between the Employer/Plan Sponsor and an insurance company. If the terms of this summary document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superceded by applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.

Section 2: Benefit Information (Self-Insured Benefits)

Plan Number:	
Type of Plan Benefit:	
Type of Plan Administration:	
Contract Administrator: <i>Responsible for plan administration and processing of claims.</i>	
Funding Agent: <i>Responsible for payment of claims and for financial risk of claims.</i>	Employer/Plan Sponsor
Funding Arrangement:	The Plan is funded through the general assets of the Employer/Plan Sponsor and through contributions by participants where applicable
Eligible Employee and Eligibility Criteria:	
Plan Premiums/Contributions:	
Special Notes:	

The benefits identified above are self-insured by the Employer/Plan Sponsor. This Plan document and summary plan description control the provision of Plan Benefits. For further information about these Plan Benefits please contact the Plan Administrator.

Section 2: Benefit Information (Self-Insured Benefits)

Plan Number:	
Type of Plan Benefit:	
Type of Plan Administration:	
Contract Administrator: <i>Responsible for plan administration and processing of claims.</i>	
Funding Agent: <i>Responsible for payment of claims and for financial risk of claims.</i>	Employer/Plan Sponsor
Funding Arrangement:	The Plan is funded through the general assets of the Employer/Plan Sponsor and through contributions by participants where applicable
Eligible Employee and Eligibility Criteria:	
Plan Premiums/Contributions:	
Special Notes:	

The benefits identified above are self-insured by the Employer/Plan Sponsor. This Plan document and summary plan description control the provision of Plan Benefits. For further information about these Plan Benefits please contact the Plan Administrator.

Section 3: SPD and Plan Document Description

This document is a Plan Document and a Summary Plan Description. When accompanied by the appropriate Certificates of Coverage, this document, along with those Certificates, becomes the Summary Plan Description. When accompanied by the appropriate Insurance Contracts, this document, along with those Contracts, become the Plan Document. The detailed Plan information required by ERISA is contained in your Certificates of Coverage and/or Insurance Contracts for each benefit.

This Plan document and Summary Plan Description may be adopted by the Employer/Plan Sponsor by executing the Adoption Agreement form, or it may be adopted by the Employer/Plan Sponsor by resolution by the Employer/Plan Sponsor's Board of Directors. In the case of an Employer/Plan Sponsor that adopts the Plan Document and Summary Plan Description using the Adoption Agreement, the Plan Document and Summary Plan Description will become effective as of the date of the Adoption Agreement. In the case of an Employer/Plan Sponsor that adopts the Plan Document and Summary Plan Description by resolution of its Board of Directors, the Plan Document and Summary Plan Description will become effective as of the effective date of the resolution.

Section 4: Termination/Modification/Amendment of the Plan

A. Right to Terminate/Modify/Amend

The Employer/Plan Sponsor has the right to amend or terminate the Plan at any time, with or without notice to participants and beneficiaries. No consent of any participant or beneficiary is required to amend or terminate the Plan.

B. Loss or Termination of Coverage

Your individual coverage terminates as of the earliest of the following events:

1. When you leave your employment;
2. When you are no longer eligible;
3. When you cease to contribute (if the Plan is contributory);
4. When the Plan is amended to eliminate your coverage;
5. Upon the occurrence of any other event terminating coverage and described in the Insurance Contract or Certificate; or
6. When the Plan terminates.

The Employer/Plan Sponsor may enter into contracts with a Contract Administrator to provide administration, or with an Insurer to provide coverages. The Employer/Plan Sponsor has the right to amend, terminate, modify or change any element of the Plan, or any relationship with a Contract Administrator or Insurer, at any time, with or without prior written notice to you or your beneficiaries.

C. Other Provisions

If you cease active work, your individual Certificates of Coverage will determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active work.

A Contract Administrator or Insurer may terminate coverage if the Employer/Plan Sponsor fails to pay the required premium in a timely manner as prescribed by the contract. A Contract Administrator or Insurer may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required, or if the Employer/Plan Sponsor fails to meet any other requirement of the Insurance Contract.

Section 5: Eligibility and Benefit Termination Specifications

A. Eligibility Requirements

This SPD and Plan Document is issued in conjunction with corresponding self-funded benefit Schedules, Certificates of Coverage or Insurance Contracts for each of the Plans identified on the previous pages. Eligibility provisions for each Plan are specified in the “Benefit Information” portion of this document. Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive certain benefits under each Plan.

Medical Coverage

1. Eligible Employees may enroll on the first day of the month following the completion of _____ months of continuous service in the employ of the Employer.
2. The date of eligibility of Employees who decline enrollment in this Plan during the initial enrollment period and later apply for coverage shall be determined as follows:
 - A late enrollee who declined enrollment during the initial enrollment period shall be eligible for coverage as of the earlier of 12 months from the date of his or her application for coverage, or at the Employer’s next open enrollment period.
 - An Employee shall not be considered a Late Enrollee if he or she, or his or her Dependent, loses coverage under another Employer health plan, and shall be eligible for coverage on the date of loss of such coverage, provided enrollment is requested within 31 days after termination of that other employer health benefit plan coverage. Employees will be required to furnish to the Plan Administrator or Contract Administrator written proof of the loss of coverage.
3. An Employee may add newly acquired Dependents and himself or herself:
 - to continue coverage of a newborn or child placed for adoption;
 - to add himself or herself, a Spouse, or any eligible Dependent the Employee or Spouse after marriage;
 - to add himself and Spouse and his/her newborn or child placed for adoption, following birth of a newborn or placement of a child for adoption.

Who Is Considered a Dependent for Medical Coverage?

1. A taxpayer's natural child (including a newborn child), stepchild, a child legally adopted or placed with the taxpayer, or an eligible foster child legally placed with the taxpayer by an authorized placement agency or by judgment, decree or other court order, who:
 - a. is unmarried;
 - b. has the same principal place of abode as the taxpayer for more than one-half of the taxable year;
 - c. is either:
 - (i) younger than 19 as of the close of the calendar year; or
 - (ii) age 19, but younger than age 24, and a full-time student during each of 5 calendar months during the calendar year in which the taxable year of the taxpayer begins, at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on; or
 - (iii) is any age if "permanently and totally disabled," meaning unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
 - d. who has not provided over one-half of his/her own support for the taxable year; and
 - e. if claimed by two or more taxpayers for a taxable year, is treated as the child of the taxpayer who is a parent of the child, or if not the parent, the taxpayer with the highest adjusted gross income for such taxable year. Note: If more than one parent claims the child, and the parents do not file a joint return together, the child will be treated as the "qualifying child" of the parent with whom the child resided for the longest period of time during the same taxable year, or if residing with both parents the same amount of time, the parent with the highest adjusted gross income.
2. An individual for whom the taxpayer provides over one-half of the individual's support for the calendar year, who is either:
 - a. a child or a descendant of a child; a brother, sister, stepbrother, or stepsister; the father or mother, or an ancestor of either; a stepfather or stepmother; a son or daughter of a brother or sister of the Eligible Employee; a brother or sister of the Eligible Employee's father or mother; a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or

- b. for the taxable year is an individual (other than the taxpayer's spouse) who:
 - (i) has the same principal place of abode as the taxpayer; and
 - (ii) is a member of the taxpayer's household, provided the relationship between the individual and the taxpayer does not violate local law.

- c. An individual described in 2a or 2b above must also:
 - (i) not be the child (as defined in Section 1 above) of the taxpayer;
 - (ii) receive from the Eligible Employee over one-half of the individual's support for the calendar year; and
 - (iii) must have gross income of less than \$2,000.

Dental Coverage

Eligible Employees may enroll on the first day of the month following the completion of _____ months of continuous service in the employ of the Employer.

Who is Considered a Dependent for Dental Coverage?

The same individuals who are considered Dependents for purposes of Medical Coverage are considered Dependents for purposes of Dental Coverage.

Life Insurance/Long Term Disability/Accidental Death and Dismemberment Coverage

Eligible Employees may enroll on the first day of the month following the completion of _____ months of continuous service in the employ of the Employer.

Vision Coverage

Eligible Employees may enroll on the first day of the month following the completion of _____ months of continuous service in the employ of the Employer.

Who is Considered a Dependent for Vision Coverage?

The same individuals who are considered Dependents for purposes of Medical Coverage are considered Dependents for purposes of Vision Coverage.

Healthcare Reimbursement/Dependent Care Reimbursement Accounts

Eligible Employees may enroll on the first day of the month following the completion of _____ months of continuous service in the employ of the Employer.

Section 6: Claims Procedures

This Section describes how claims are determined under the Plan, and how appeals may be taken from Adverse Benefit Determinations. Please make sure you read the definitions at the end of this Section so you understand how these provisions work.

The Claimant, at all steps of the claims process, may be represented by another person, who may be, but is not required to be, a lawyer. The Claimant will be responsible for paying the fees and expenses of his or her representative. The Plan Administrator may require evidence that it considers reasonable to establish that an individual is actually the authorized representative of the Claimant.

Except for claims decisions that it delegates to a Contract Administrator, the Plan Administrator has exclusive responsibility for deciding claims for benefits under the Plan and for deciding any appeals of denied claims. The Plan Administrator has the authority, in its complete discretion, to interpret the terms of the Plan, including any insurance policies, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on the Claimant to the fullest extent permitted by law.

Claims for Medical, Dental, Vision and Health Care Flexible Spending Account Benefits

Urgent Care Claims

If a Claimant submits a claim for Urgent Care, the Contract Administrator shall notify Claimant of its determination on the claim as soon as possible, but no later than seventy-two (72) hours after the claim is filed. However, if the Claimant does not provide Contract Administrator with enough information to decide the claim, the Contract Administrator shall notify the Claimant within twenty-four (24) hours after it receives the claim of the further information that is needed. The Claimant shall have forty-eight (48) hours to provide that information. If the needed information is provided, the Contract Administrator shall notify the Claimant of its decision within forty-eight (48) hours after the Contract Administrator received the information. If the needed information is not provided, the Contract Administrator shall notify the Claimant of its decision within one hundred twenty (120) hours after the claim was received. The Contract Administrator may notify the Claimant of its decision by phone and later mail a written notice if the claim is denied.

Concurrent Care Claims

If the Claimant wants to extend the course of a treatment beyond the initial time period or increase the number of treatments and the claim involves Urgent Care, the Contract Administrator shall notify the Claimant of its decision within 24 hours of receipt of the claim, provided that the claim has been made by the Claimant at least 24 hours prior to the end of the treatment time period. If the Claimant wants to extend the course of treatment beyond the initial

time period or increase the number of treatments and the claim is not urgent, then the Contract Administrator must notify the Claimant of its decision within 30 days after a request is made. If special circumstances require more time, the Claimant shall be informed in writing (before the end of the 30-day period) of the reason for the delay and the date a decision will be made. In no case will the extension exceed 45 days after the claim is filed.

Pre-Service Claims

If a Claimant submits a Pre-Service claim, the Contract Administrator shall notify the Claimant of its determination on the claim within a reasonable period, but no later than fifteen (15) days after the claim is filed. If an extension of this 15-day period is required due to matters beyond the control of the Plan, the Contract Administrator shall notify the Claimant in writing, prior to the end of the 15-day period, of the circumstances requiring the extension and the date that the Contract Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information.

Post-Service Claims

If a Post-Service Claim is filed, the Contract Administrator shall have a reasonable period of time, up to 30 days, in which to review the claim and to notify the Claimant of its decision on the claim. If an extension of this 30-day period is required due to matters beyond the control of the Plan, the Contract Administrator shall notify the Claimant in writing, prior to the end of the 30-day period, of the circumstances requiring the extension and the date that the Contract Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information. If the Claimant or the medical care provider made a mistake in filing the claim, the notice shall tell the Claimant how to correct it.

Rules Applicable to All Claims for Medical, Dental, Vision and Health Care Flexible Spending Account Benefits

If the claim is denied, the Claimant shall receive a written notice from the Contract Administrator that will explain the reason for the denial, specify the Plan provisions on which the denial was based, describe the benefit claims procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice shall also inform the Claimant if the Contract Administrator relied on any internal rule or guideline when it made its decision, and that a copy of the rule or guideline will be provided to the Claimant free of charge, upon request. If the Contract Administrator denies the claim because it determines that the claim is not medically

necessary or that the treatment used is experimental or investigational, the notice will specify what Plan provision(s) the decision is based on as well as explain any scientific judgments the Contract Administrator made.

If the claim is denied in whole or in part, the Claimant may appeal the Adverse Benefit Determination using the procedures described below.

Claims for Life Insurance or AD&D Benefits

In the case of claims for life insurance benefits, the Contract Administrator shall notify the Claimant of its determination on the claim no later than 90 days after receipt of the claim by the Contract Administrator, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If the Contract Administrator determines that an extension of time for processing the claims is required, the Claimant shall be provided with written notice of the extension prior to the expiration of the initial 90-day period. In no case will the extension exceed 180 days after the date the claim was filed.

If the claim for life insurance benefits under the Plan is partly or entirely denied, the Claimant will receive written notice from the Contract Administrator. The notice will explain the reason for the denial, specify the Plan provisions on which the denial is based, describe the appeals procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied.

If the claim is denied in whole or in part, the Claimant is entitled to appeal the Adverse Benefit Determination using the procedures described below.

Claims for Long-Term Disability Benefits

In the case of claims for long-term disability benefits, the Contract Administrator shall notify the Claimant of its determination on the claim no later than 45 days after receipt of the claim by the Contract Administrator, unless the Contract Administrator determines that an extension is required due to matters beyond the control of the Plan. If the Contract Administrator determines that additional time is required to process the claim, the Claimant must be provided with written notice of the extension prior to expiration of the initial 45-day period. The notice will explain the circumstances requiring an extension.

If prior to the end of the first 30-day extension period, the Contract Administrator determines that due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the Contract Administrator may have an additional 30 days to make a decision. The Claimant will be provided written notice prior to the end of the initial 30-day extension period, explaining the circumstances requiring the extension and the date as of which the Contract Administrator expects to render a decision. The extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Claimant will be

given at least 45 days within which to provide the information specified in the notice. In no case will the extension exceed 105 days after the date the claim was filed.

If the claim is denied, the Claimant will receive a written notice from the Contract Administrator that will explain the reason for the denial, specify the Plan provisions on which the denial was based, describe the benefit claims procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice will also inform the Claimant if the Contract Administrator relied on any internal rule or guideline when it made its decision, and that a copy of the rule or guideline will be provided to the Claimant free of charge, upon request.

If the claim is denied in whole or in part, the Claimant is entitled to appeal using the procedures described below.

Appealing A Claim Denial

In the case of claims involving medical, dental, vision, health care flexible spending account and long-term disability claims, the Claimant has 180 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination. In the case of claims involving life insurance or AD&D, the Claimant has 60 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination.

The Claimant will be provided, upon request and free of charge, with copies and/or reasonable access to all documents, records and other information relevant to his or her appeal. The Contract Administrator's review must take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Contract Administrator's review must not give any deference to the initial Adverse Benefit Determination. No individual who took part in the initial Adverse Benefit Determination, nor a subordinate of anyone who took part in the initial Adverse Benefit Determination, may participate in the appeal decision.

If an appeal is based in whole or in part on a medical judgment, including a determination with regard to whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Contract Administrator will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the judgment. This professional may not be an individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of anyone consulted in connection with the initial Adverse Benefit Determination. The Contract Administrator shall identify and disclose to the Claimant any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon in making the determination.

Special Timing Rule Governing Appeals of Medical, Dental and Vision Urgent Care Claims

In the case of a claim involving Urgent Care under the Plan, the Contract Administrator shall allow the Claimant to submit an expedited appeal either orally or in writing. If an expedited appeal is requested, all necessary information, including the Contract Administrator's determination on review, will be transmitted between the Contract Administrator and the Claimant by telephone, facsimile or other expeditious method.

Rules Concerning How Long The Contract Administrator May Take To Decide An Appeal

The Contract Administrator will decide an appeal from a denied life insurance or AD&D claim no later than 60 days after receipt of the Claimant's request for appeal, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing a claim, the Contract Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 60-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 120 days after the appeal is filed.

The Contract Administrator will decide an appeal from a denied long-term disability claim no later than 45 days after receipt of the Claimant's request for appeal, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing the claim, the Contract Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 45-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 90 days after the appeal is filed.

If the appeal involves an Urgent Care Claim for medical, dental or vision benefits under the Plan, the Contract Administrator will notify the Claimant of its decision on appeal as soon as possible taking into account pertinent medical matters and considerations, but in no event later than 72 hours after receipt of the request for appeal.

If the appeal involves a Pre-Service Claim for medical, dental or vision benefits under the Plan, the Contract Administrator will notify the Claimant of its decision on appeal within a reasonable period of time appropriate to the medical circumstances. This period will not exceed 30 days after the date upon which the Contract Administrator received the request for appeal.

If the appeal involves a Post-Service Claim for medical, dental, vision or health care flexible spending account benefits under the Plan, the Contract Administrator will notify the Claimant of its decision on appeal within a reasonable period of time, which will not exceed 60 days after the date upon which the Contract Administrator received the request for appeal.

Contents Of The Appeal Decision

The Contract Administrator's decision will be furnished to the Claimant in writing within the time periods described above. If an appeal is denied in whole or in part, the notice of decision shall set forth, in a manner calculated to be understood by the Claimant, the specific reason or reasons for the denial; reference to the specific plan provisions upon which the denial was based; a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim for benefits; and a statement describing any voluntary dispute resolution options.

If an internal rule, guideline, protocol or other similar criterion was relied upon in denying an appeal, the Contract Administrator must either furnish the Claimant with a copy of the specific rule, guideline, protocol or other criterion, or provide the Claimant with a statement that the rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination, and that a copy of these materials will be provided to the Claimant free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the Contract Administrator must either furnish the Claimant with an explanation of the scientific or clinical judgment upon which the decision was based, applying the terms of the Plan to the Claimant's case, or a statement that this explanation will be provided free of charge upon request.

Definitions

"Adverse Benefit Determination" means a denial, reduction, or termination of a benefit, including a failure to pay all or part of a benefit claim, whether based on a determination that the Claimant is ineligible to participate in the Plan or based on a utilization review. The term also includes failure by the Plan to cover an item or service for which benefits are otherwise provided because it is found to be experimental or investigational, or because it is found not to be medically necessary or appropriate.

"Claimant" means any Participant, Beneficiary or Dependent who is making a claim for a benefit.

"Concurrent Claim" means any benefit claim for medical, dental or vision benefits where the Contract Administrator has approved an ongoing course of treatment over a set period of time, or a set number of treatments, but the Contract Administrator cancels the treatment before the end of that time period or reduces the number of treatments.

"Post-Service Claim" means any benefit under the Plan that is not a Pre-Service Claim and does not involve urgent care.

"Pre-Service Claim" means any benefit claim on account of which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

“Urgent Care” or “Urgent Care Claim” means any claim for medical care or treatment under the Plan if application of time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the Claimant to regain maximum function; or in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Contract Administrator or the Plan Administrator will determine if a claim involves Urgent Care by applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. Nevertheless, if a physician with knowledge of the Claimant’s medical condition determines that the claim involves Urgent Care, this decision will control.

Section 7: Statement of Your Rights Under ERISA

As a participant in [Name of Plan], you are entitled to certain rights and protection under the Employee 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 at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) (if any) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (“EBSA”), formally known as the Pension and Welfare Benefits 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. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report for a Plan Year.

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 this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health

plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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, in writing, 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 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 requested materials were not sent because of reasons beyond the control of the Plan 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. No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Section 8: Description of Types of Funding Arrangements

A. Fully Insured Plan

In a fully insured plan, benefits are provided under a group insurance contract entered into between your Employer/Plan Sponsor and the insurance company identified as the Contract Funding Agent. Claims for benefits are sent to the insurance company. The insurance company, not your Employer, is responsible for paying claims and for the financial risk of paying claims under the plan. (However, the insurance company and Employer share the responsibilities for administering the plan.) Insurance premiums for Plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer out of the general assets of the Employer.

B. Self-Insured Plan

In a self-insured plan or a partially self-insured plan, the Employer/Plan Sponsor hires the Contract Administrator to process claims under the plan. The Contract Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract Administrator. The Contract Administrator processes the claims, then requests and receives funds from the Employer to pay the claims and make payment on the claims to health care providers. The Employer is ultimately responsible for providing plan benefits, not the Contract Administrator. (However, the Contract Administrators and Employer share the responsibilities for administering the plan.) Plan benefits are paid by the Employer out of the general assets of the Employer. There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) are also paid by the Employer out of the general assets of the Employer.

C. Pre-paid Plan

In a pre-paid plan, benefits are provided under a contract entered into between the Employer/Plan Sponsor and the Contract Administrator. Premiums are due in advance of services being received. Providers are typically paid on a per-employee basis for basic services and on a fee-for-service basis for other services. The Contract Administrator negotiates payment arrangements with providers. Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer out of the general assets of the Employer.

Section 9: Important Disclosures

A. Maternity Hospital Length of Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

B. Women's Health and Cancer Rights Act of 1998

The federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1. Reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3. Prostheses;
4. Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under your plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments.

C. Qualified Medical Child Support Orders

A Plan participant or beneficiary may obtain without charge a copy of the Plan's procedures for compliance with Qualified Medical Child Support Orders by contacting the Plan Administrator.

Section 10: Continuation Coverage (COBRA)

Under Federal law, you may have the right to continue your health insurance under the [Name of Plan] (the “Health Plan”) for a limited time period at your own expense if you lose coverage for certain reasons. This continuation of coverage is called COBRA. COBRA continuation coverage is available to an employee and/or his spouse and dependent children whose group health insurance under the Health Plan ends as a result of a *qualifying event*.

A. Qualifying Events Which May Trigger Your Right to COBRA Coverage

If you are the EMPLOYEE, the *qualifying event* which triggers your right to continue health coverage is:

- Termination of employment (for other than gross misconduct) or a reduction in hours;
- You may also have a “second-chance” COBRA election if your termination of employment resulted in eligibility for Trade Assistance Act benefits.

If you are the SPOUSE of an Employee, the *qualifying events* which trigger your right to continue health coverage are:

- Termination of the Employee’s employment (for other than gross misconduct) or a reduction in hours;
- Your divorce or legal separation from the Employee;
- The Employee becoming entitled to Medicare under Part A, Part B, or both (if this event causes the Employee to lose coverage under the Health Plan.)
- The death of the Employee.

If you are the DEPENDENT CHILD of an employee, the *qualifying events* which trigger your right to continue health coverage are:

- Termination of the Employee’s employment (for other than gross misconduct) or a reduction in hours;
- The divorce or legal separation of your parents;
- Ceasing to be a dependent under the terms of the Health Plan;
- The Employee becoming entitled to Medicare under Part A, Part B, or both (if this event causes the Employee to lose coverage under the Health Plan);

- The death of the Employee.

Qualified Beneficiaries are limited to the Employee, the Employee's spouse at the time of the initial qualifying event and the Employee's Dependent Children at such time. However, a CHILD BORN TO OR ADOPTED BY THE COVERED EMPLOYEE during the period of COBRA coverage, may be enrolled immediately for continuation coverage as a Qualified Beneficiary.

Also, a title 11 bankruptcy proceeding of the Employer may trigger COBRA rights with respect to certain retired Employees and their families.

B. The Maximum Period of COBRA Coverage

The maximum period of continuation coverage that you can elect is as follows:

18 months	In the case of a termination of employment (for other than gross misconduct) or a reduction in hours.
29 months	If the Employee, his or her spouse or his or her dependent child is disabled (as determined under the Social Security Act) within 60 days of the date of the Employee's termination of employment or reduction in hours.
36 months	Divorce, separation, loss of dependent status, or death.

The period of coverage begins to run on the date the qualifying event occurs, even if the Employer pays for you to have continued health coverage for a certain period of time after the date of the qualifying event.

There are special rules that can extend the maximum period of COBRA coverage in the event multiple qualifying events occur, such as when an Employee terminates employment and dies or is divorced within the 18-month COBRA continuation period.

C. Notice Obligations of Qualified Beneficiaries

If you and your spouse divorce or become legally separated, if a dependent child is no longer eligible as a dependent for coverage under the Health Plan, or if your spouse or dependent experiences a second qualifying event ("multiple qualifying event"), you or your spouse or dependent are required to notify the Plan Administrator of the occurrence of this event within 60 days of the date of the event.

A Qualified Beneficiary who experiences multiple qualifying events will have an extension of the period of COBRA coverage. For example, if the Employee becomes entitled to Medicare

while COBRA coverage is in force, the spouse and dependent children, if covered at that time, will have an extension of the period of COBRA coverage. If the Employee dies or divorces while COBRA coverage is in force, the spouse and dependent children, if covered at that time, will have an extension of the period of COBRA coverage. Likewise, if a dependent child ceases being a dependent for purposes of coverage under the health plan, that dependent could have extended COBRA coverage.

During the COBRA continuation period, you and/or your spouse are responsible for notifying the Employer in writing within 30 days of the birth (to the Employee only) or adoption (by the Employee only) of a dependent child. If you and/or your spouse do not make this notification within this 30-day period, the newborn or adopted child will not be added to continuation coverage as a Qualified Beneficiary and the Employee will only be allowed to add the newborn or adopted child as a dependent child at the next open enrollment period for active Employees, if the Employee still has coverage under COBRA.

In addition, if you or your spouse or dependent child are disabled (as determined under the Social Security Act) within the first 60 days from the date of your termination of employment (for other than gross misconduct) or reduction in hours, then you must notify the Plan Administrator in writing of the determination of disability within 60 days of the determination and before the end of the initial 18 months of COBRA continuation coverage in order to be eligible to elect an additional 11 months of COBRA coverage. The disabled individual may be required to pay a higher premium for this additional 11 months of coverage. In addition, such person is required to notify the Plan Administrator of a determination under the Social Security Act that he or she is no longer disabled within 30 days of such determination.

You must notify the Plan Administrator in writing as soon as possible after the date you or your spouse or dependent children are covered under another group health plan or in the event any of you becomes entitled to Medicare.

D. The Type of Health Coverage Available to You Under COBRA

The type of health coverage available to you is the same coverage you had before the qualifying event occurred. However, if coverage under the Health Plan is later modified for all beneficiaries who are similarly situated to you, but for whom no qualifying event has occurred, then your coverage will change also.

In addition, at any open enrollment period for Employees covered by the Health Plan, you, your spouse and/or dependent children who were covered under the Plan on the day before the qualifying event, or a child born to or adopted by you during your COBRA continuation coverage, may make any election that is offered to similarly situated employees to add or delete family members, or add, delete or change coverage.

E. Termination of COBRA Coverage

If you elect COBRA continuation coverage, then whether you are the EMPLOYEE, the SPOUSE or DEPENDENT CHILD, your COBRA continuation coverage will terminate at the *earliest* of the following dates:

- the date the maximum period of coverage expires,
- the date your coverage under the Plan ceases because a premium payment is not made on time,
- the date you become covered under another group health plan unless that plan contains a pre-existing condition provision which excludes from coverage a condition that you have; however, your continuation coverage may be cut short if such pre-existing condition exclusion does not apply because of the Health Insurance Portability and Accountability Act of 1996 creditable coverage rules.
- the date you become entitled to Medicare benefits,
- the date [Name of Employer] no longer provides any group health plan, or
- the date on which a special cause, if any (such a filing a false claim under the Plan), under the health program would terminate the coverage of a similarly situated participant or beneficiary under the Plan for whom no qualifying event has occurred.

F. Electing COBRA Coverage

In order to receive COBRA continuation coverage, you must make an election to receive the coverage on a COBRA Election Form. You must make the election within 60 days of the later of the date you would lose coverage because of a qualifying event or the date a COBRA Notice is sent to you by your Employer. You make the election by completing the COBRA Election Form, and returning it to the Plan Administrator, [Employer Name and Address], within the 60 day period. The election form will provide you with additional information regarding your COBRA election.

If you are the spouse of an Employee, you are entitled to make a separate election for yourself and any minor dependents.

If you are an Employee eligible to receive Trade Adjustment Assistance (TAA) benefits, and you (i) lost group health plan coverage due to a job loss that resulted in eligibility for TAA benefits, and (ii) failed to elect COBRA during your original COBRA election period, you may be entitled

to a second 60-day COBRA election period. The new election period begins on the first day of the month in which you are certified for TAA benefits, but your election must be made within six months of the initial loss of group health coverage. In addition, the petition for trade assistance benefit certification must not have been filed before November 4, 2002.

You may make an election under the second 60-day election period by completing the COBRA Election Form, and returning it to the Plan Administrator, [Employer Name and Address], within the second 60-day period and before expiration of the six month eligibility period. If you elect COBRA under this “second chance” provision, your maximum period of continuation coverage will be based on the date of your original qualifying event. Your coverage will begin on the first day of the 60-day “second-chance” election period. In addition, the period between your original loss of coverage and the beginning of the 60-day second chance election period will not count against the 63-day HIPAA break in coverage rule for purposes of pre-existing conditions. The election form will provide you with additional information regarding electing COBRA during this second-chance period.

If you are eligible for TAA benefits, you may be eligible to receive the Health Care Tax Credit (“HCTC”). Please contact your Plan Administrator for more information.

G. Paying for COBRA Coverage

You will be required to make timely premium payments in order to continue your coverage. Your first month’s premium payment and all other monthly premium payments then due must be paid within 45 days after the date you elect COBRA continuation coverage. Thereafter, premiums will be due in advance on the 1st of the month for which coverage is being purchased. You must pay each premium within 30 days of the first day of the month to have coverage for that month and to prevent termination of your right to COBRA coverage.

Under the law, you are responsible for paying the continuation coverage premiums, which equal 102% of the regular group premiums under the plan, and will change whenever the regular group premiums change. In the event of a Medicare-qualifying disability, the premiums for months 19 through 29 will equal 150% of the regular group premiums. In all cases, payments must be in the form of a check or money order made payable to [Employer Name]. If a personal check bounces, a handling fee must be paid, no further personal checks will be accepted, and applicable deadlines will not be delayed. You may be entitled to have the federal government or state Medicaid authorities pay all or a portion of the premiums for your continuation coverage; for more information, contact your local Medicaid office.

IF YOU DO NOT MAKE THE COBRA ELECTION WITHIN THE SPECIFIED 60-DAY PERIOD OR IF YOU DO NOT MAKE A PREMIUM PAYMENT ON TIME, THEN YOUR INSURANCE WILL CEASE WITHOUT FURTHER NOTICE AND CANNOT BE REINSTATED UNLESS YOU ARE ELIGIBLE FOR A “SECOND-CHANCE” COBRA ELECTION.

H. Conversion Policy

The law requires that at the time of the qualifying event and again at the expiration of the 18-, 29- or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health policy if the [Employer Name] Group Health Plan provides such an option. You should contact the Plan Administrator if you wish to exercise this option, if available. Please remember that [Employer Name] retains the right to eliminate the conversion option from the Health Plan at any time, which will affect those individuals who have not yet exercised the option. However, some state insurance laws require group health policies to contain conversion options. To determine whether you reside in a state that has enacted laws that require policies to provide conversion rights, please contact the Plan Administrator.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

I. For California Employees: California State Law “Cal-COBRA” Coverage

California Employees who begin receiving COBRA on or after January 1, 2003, are eligible to receive up to 18 months of Cal-COBRA coverage, for a total of 36 months of combined federal COBRA and Cal-COBRA. The 36-month period dates back to the original date of the COBRA qualifying event. COBRA must be exhausted before an Employee or qualified beneficiary can become eligible to receive Cal-COBRA coverage. This Cal-COBRA coverage is not available to Employees and Qualified Beneficiaries who receive 36 months of COBRA. The Cal-COBRA coverage is available for employees and qualified beneficiaries who receive either 18 months or 29 months of COBRA coverage.

Cal-COBRA will terminate the earliest of the following dates:

- the date the maximum period of coverage expires,
- the date your coverage under the Plan ceases because a premium payment is not made on time,
- the date you become covered, after electing continuation coverage, under another group health plan that does not impose pre-existing condition exclusion for any pre-existing condition that you may have,
- the date your Employer no longer provides any group health plan,
- the date you move out of the insurer’s service area,
- the date you become entitled to Medicare benefits after electing coverage, or

- you commit fraud or deception in the use of benefits.

Cal-COBRA applies to medical care plans, not dental-only or vision-only care plans. This Cal-COBRA coverage applies only to coverage under an insured plan or HMO, not under a self-insured plan. You will receive additional information from the carrier prior to your scheduled end-date for COBRA.

The cost for this "Cal-COBRA" is 110% of the applicable rate under the group plan. The cost for disability coverage under "Cal-COBRA" coverage is 150% of the applicable rate under the group plan. Premiums must be remitted to the insurer or HMO, not to your employer.

The insurer or plan will notify individuals of their conversion rights during the 180-day period ending on the date Cal-COBRA coverage ends. If the former Employer terminates its group contract with the insurer or HMO, the insurer or HMO is not required to notify the individual of the right to convert to an individual policy. However, the replacement carrier will be required to cover any former employees (and spouses or former spouses) who have elected this "Cal-COBRA" coverage.

Section 11: HIPAA

As required by law, this Plan complies with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions apply to group health plans only, not all benefit coverages offered under this Plan.

A. Continuity of Coverage

HIPAA requires that your group health Plan reduce or eliminate the exclusionary period of coverage for pre-existing conditions under your group health plans (not long term disability plans), if you have creditable coverage from another Plan. Typically you should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or if you request it up to 24 months after losing coverage. Typically, without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

B. Special Enrollment Rights

HIPAA also requires that group health plans provide special mid-year enrollment opportunities to certain employees and/or their dependents in two circumstances: 1) loss of other coverage, or 2) acquisition of a new dependent. A participant enrollment under these special enrollment rules is not a late enrollment, and is not subject to the late enrollment penalties prescribed by HIPAA.

If you are covered under another group health plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your dependents may enter the Plan under special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of other coverage or the employer's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the Plan receives the enrollment form.

If you acquire a new dependent, by marriage, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new dependent in the group health Plan. You must request enrollment in writing within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption.

Effective on and after April 1, 2009, a Participant may revoke or modify his benefit election during the current Plan Year if the revocation or modification is on account of an Employee, spouse or Dependent: (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP, and the Participant provides a written election notice to the Plan Administrator within 60 days of the loss of coverage or eligibility for premium assistance.

C. Privacy Of Health Information

This section describes the medical information privacy practices of the Plan and that of any third party that assists in the administration of the Plan's group health claims (medical, prescription drugs, dental, and vision). For a more complete explanation, see the "Notice of Privacy Practices" which was given to you in connection with these rights. Questions about the Plan's privacy practices should be addressed to the Plan's Privacy Official who is *[Insert Name of the Privacy Official]* and who may be contacted at *[Insert telephone number of the Privacy Official]*.

D. Our Pledge Regarding Medical Information

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information to the employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them.

The Plan may disclose summary health information to the employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plan.

The Plan may disclose protected health information to carry out Plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information

to the employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer.

A limited number of employees of the employer will have access to protected health information for the purposes of carrying out Plan administration functions in the ordinary course of business.

E. How the Plan May Use and Disclose Medical Information About You

The following categories describe different ways that the Plan uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** The Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Plan may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.
- **For Payment.** The Plan may use and disclose protected health information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may share protected health information with a utilization review or pre-certification service provider. Likewise, the Plan may share protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.
- **For Health Care Operations.** The Plan may use and disclose protected health information about you for other Plan operations which are necessary to run the Plan. For example, the Plan may use protected health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.
- **As Required By Law.** The Plan will disclose protected health information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

- **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose protected health information about you in a proceeding regarding the licensure of a physician.
- **Organ and Tissue Donation.** Information may be disclosed to another health plan maintained by the Company for purposes of facilitating claims payments under the Plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.
- **Military and Veterans.** If you are a member of the armed forces, the Plan may release protected health information about you as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** The Plan may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** The Plan may disclose protected health information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** The Plan may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, the Plan may disclose protected health information about you in response to a court or administrative order. The Plan may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** The Plan may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement; about a death the Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** The Plan may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information about you to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** The Plan may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

F. Your Rights Regarding Medical Information About You

You have the following rights regarding protected health information the Plan maintains about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. If you request a copy of the information, the Plan may charge a fee for the costs copying, mailing, or other supplies associated your request. The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.
- **Right to Amend.** If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan is not required to agree to your request however.
- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

G. Other Uses of Medical Information

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Plan will be made only with your written permission. If you provide the Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain its records of the benefits that the Plan provided to you.

OPTIONAL HIPAA PRIVACY AND SECURITY PROVISIONS FOR MODEL WELFARE PLAN SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Instructions: The privacy and security provisions of the Health Insurance Portability and Accountability Act (“HIPAA”) require in certain (but not all) cases that group health plan documents contain provisions which limit the uses and disclosures which employers make of

“protected health information” they receive from the Plan, protect the privacy and security of such information, and bind the employer to honor individual HIPAA rights. It is critical to understand that all group health plans are *not* required to contain HIPAA provisions.

Generally, if an employer does not receive protected health information from its group health plan or plans, there is no requirement that documents contain HIPAA privacy or security provisions. HIPAA privacy provisions are required if the plan is otherwise subject to HIPAA privacy requirements and the employer performs plan administrative functions (for example, the employer determines claims appeals) and receives protected health information in the process. Also, if the employer receives protected health information for other reasons and the plan is subject to HIPAA privacy requirements, the plan must contain HIPAA provisions. HIPAA security requirements must appear in the Plan if the employer/Plan sponsor creates, receives, maintains or transmits electronic protected health information.

For a more detailed discussion of protected health information and when plans must be amended to contain HIPAA privacy and security provisions, you should contact your employee benefits attorney. Additional information can also be found in the HIPAA Privacy section of *HRinsider*.

The following HIPAA privacy and security provisions are “generic” and intended for use with the wrap SPD/plan document. That document already contains necessary HIPAA SPD language (see pages 29-33 above), although the following language is necessary to ensure that the Plan itself includes HIPAA language if such terms are necessary. The privacy provisions are designed to be inserted as a new Section 11A, while the security provisions are Section 11B.

As with all generic language, great care should be taken when using it or attempting to adapt it to specific situations. Employers and their advisors should always consult with an attorney familiar with employee benefit matters before using all or part of the model language. In addition, please note that the generic language has a provision which must be completed with appropriate information. See Section 11A, Part F(3), which requires identification of groups of employees with access to protected health information.

GENERIC PLAN DOCUMENT HIPAA PRIVACY LANGUAGE

Section 11A. Plan Document Provisions for Welfare Benefit Plans Required to Contain HIPAA Privacy Provisions.

HIPAA PRIVACY COMPLIANCE

A. Preamble

This provision is made effective as of the date stated below, and governs all group health plans maintained by the Employer and on account of which the Employer is responsible to ensure compliance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). For simplicity, these plans are collectively referred to herein as the “HIPAA

Plans”. This provision allows the HIPAA Plans to disclose Protected Health Information to the Employer in certain situations as permitted by HIPAA. References in this provision to disclosures from the HIPAA Plans made to the Employer include disclosures to certain employees of the Employer, as described below. If this provision conflicts in any way with a HIPAA privacy provision which has already been included in any of the HIPAA Plans, the provision already in the HIPAA Plan or Plans prevails.

B. Effective Date

This provision is effective on the later of April 14, 2003 or the date upon which HIPAA compliance is required for the HIPAA Plans. This date is referred to as the “Effective Date.”

C. Disclosures of Summary Health Information

The HIPAA Plans (including a Health Insurance Issuer or an HMO with respect to the HIPAA Plans) may disclose Summary Health Information to the Employer if it requests this information in order to obtain premium bids for health insurance coverage under the HIPAA Plans, or in order to modify, amend or terminate any of the HIPAA Plans.

D. Enrollment and Disenrollment Information

The HIPAA Plans may disclose information to the Employer concerning whether or not an Individual is participating in the HIPAA Plans, or has enrolled or disenrolled from a Health Insurance Issuer or HMO offered by any of the HIPAA Plans.

E. Disclosures Pursuant to an Authorization

The HIPAA Plans may disclose Protected Health Information to the Employer if the disclosure is made pursuant to a valid Authorization and the information is used as described in the Authorization. In particular, the HIPAA Plans may disclose Protected Health Information to the Employer pursuant to an Authorization to assist employees and their beneficiaries in connection with their claims under the HIPAA Plans, or to help them understand the terms of the HIPAA Plans as they may relate to a particular condition or claim.

F. Disclosures for Administration Purposes

- (1) The HIPAA Plans may disclose Protected Health Information to the Employer so it can carry out its administrative functions under the HIPAA Plans. These functions include Payment and Health Care Operations, including without limitation, quality assurance, claims processing, processing and deciding appeals, claims auditing, claims monitoring, monitoring and managing carve-out plans such as vision and dental coverages, procuring stop-loss coverage, and reminding participants and beneficiaries of appointments or advising them of potential alternative treatments or services. For purposes of this provision, administrative

functions do not include any of the matters described in Sections C, D, or E above, do not include any employment-related functions or functions in connection with any other benefit or benefit plans of the Employer, and do not include any disclosures which otherwise conflict with the Privacy Rules. Disclosures of Protected Health Information for HIPAA Plans' administrative purposes may only be made if the conditions described in Sections F(2) and F(3) below are met.

- (2) The Employer must agree and comply with the following requirements before the HIPAA Plans may disclose Protected Health Information to the Employer for HIPAA Plans' administrative purposes:
 - (a) the use or disclosure must be described in the HIPAA Plans' Notice of Privacy Practices issued pursuant to 45 CFR 164.520;
 - (b) the Employer must certify that the HIPAA Plans' documents have been amended as required by 45 CFR 164.504, and that it agrees to adhere to the requirements of these provisions;
 - (c) the Employer may not use or further disclose Protected Health Information provided to it except as permitted by the HIPAA Plans' documents (as amended to comply with HIPAA), or as required by law;
 - (d) the Employer will insure that any agents or subcontractors to whom it provides Protected Health Information received from the HIPAA Plans will agree to the same restrictions and conditions on the use and disclosure of this information that apply to the Employer;
 - (e) the Employer will not use or disclose Protected Health Information received from the HIPAA Plans for any employment-related actions or decisions, or in connection with any other benefit or benefit plan it maintains;
 - (f) the Employer will report to the HIPAA Plans any use or disclosure of PHI which it has received from the HIPAA Plans and which is inconsistent with allowed uses and disclosures, to the extent it becomes aware of such uses and disclosures;
 - (g) the Employer will make the Protected Health Information it receives from the HIPAA Plans available to Individuals as required by 45 CFR 164.524 (pertaining to inspection and copying); 45 CFR 164.526 (pertaining to provision); and 45 CFR 164.528 (pertaining to accounting);

- (h) the Employer will make its internal practices, books and records relating to the use and disclosure of PHI it receives from the HIPAA Plans available to the Secretary of Health and Human Services or his or her designee, to determine the HIPAA Plans' compliance with the Privacy Rules;
 - (i) the Employer will, if feasible, return or destroy all Protected Health Information received from the HIPAA Plans in any form, and retain no copies, when the information is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Employer will limit further uses and disclosures of the Protected Health Information to those purposes which make the return or destruction infeasible.
- (3) The Employer must provide for adequate separation between itself and the HIPAA Plans. To do so, only the following groups of employees or persons under the Employer's control will have access to Protected Health Information from the HIPAA Plans:

[INSERT NAMES AND/OR TITLES]

Access to Protected Health Information by the above persons shall be restricted so that such persons receive only the minimum Protected Health Information necessary to accomplish the administrative functions which they perform for the HIPAA Plans. If any of these persons or other employees of the Employer do not comply with the requirements of the HIPAA Plans in respect to the use and disclosure of Protected Health Information, the Employer will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. These sanctions will be imposed in accordance with the Employer's normal disciplinary policies, and can include termination of employment.

G. No Other Disclosures of Protected Health Information

The HIPAA Plans will not disclose Protected Health Information to the Employer (and will not cause a Health Insurance Issuer or HMO to disclose Protected Health Information to the Employer) except as described in this provision.

H. Definitions

- (1) Authorization. A document signed by an Individual authorizing disclosure of Protected Health Information and complying with the requirements of 45 CFR 164.508.

- (2) Health Care Operations. “Health Care Operations” mean:
- (a) Any of the following activities of the Plan:
- (i) conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines specific to the Plan;
 - (ii) population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives, and related functions which do not involve Treatment;
 - (iii) reviewing the competence or qualification of health care professionals, evaluating practitioner or provider performance, training of students or practitioners in which the students or practitioners learn under supervision to practice or improve their professional skills, training non-health care professionals, and accreditation, certification, licensing or credentialing activities;
 - (iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance contract or health benefits, as well as ceding, securing or placing a stop-loss or excess loss insurance contract relating to health claims (as long as the requirements of 45 CFR 164.514 are met);
 - (v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 - (vi) business planning and development, such as conducting cost-management and planning which pertain to running the Plan, including developing and administering formularies and administering, developing or improving methods of payment or coverage policies; and
 - (vii) business management and general Plan administrative activities, including but not limited to:
 - management activities related to HIPAA privacy compliance;

- customer service, including providing data analysis for plan sponsors, as long as Protected Health Information is not disclosed in the process;
 - resolution of internal grievances;
 - merger or consolidation of the Plan with another health plan, and due diligence related to the merger or consolidation; and
 - consistent with the requirements of 45 CFR 164.514, creating de-identified health information or a limited data set.
- (3) Health Care Provider. The term “Health Care Provider” means a provider of services, including a provider of medical or health services, as defined in the Social Security Act, and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.
- (4) Health Information. “Health Information” means any information, whether oral or recorded in any form or medium, that:
- (a) is created or received by a Health Care Provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and
 - (b) relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.
- (5) Health Insurance Issuer. The term “Health Insurance Issuer” means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. The term does not include a group health plan.
- (6) Individual or Individuals. An “Individual” is the person who is the subject of Protected Health Information.
- (7) Individually Identifiable Health Information. The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

(8) Payment. “Payment” means:

- (a) the activities of the Plan (or another health plan) to obtain premiums or to determine or fulfill its responsibility for coverage or providing benefits; or
- (b) the activities of the Plan or a Health Care Provider to obtain or provide reimbursement for providing health care.

Examples of Payment activities include, but are not limited to:

- (i) determination of eligibility or coverage, including coordination of benefits or determining cost sharing amounts;
- (ii) determining subrogation of health claims;
- (iii) risk adjusting amounts due based on an Individual’s health status and demographic characteristics;
- (iv) billing, claims management, collection activities, obtaining payment under a stop-loss or excess loss insurance policy, and related health care data processing;
- (v) review of health care services to determine medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- (vi) utilization review activities, including precertification or preauthorization of claims and concurrent or retrospective review of services; and
- (vii) disclosure to consumer reporting agencies of any of the following information relating to collection of premiums or reimbursement:
 - name and address;
 - date of birth;
 - social security number;
 - payment history;
 - account number; and
 - name and address of the Plan or of a Health Care Provider.

- (9) Privacy Rule or Rules. The terms “Privacy Rule” or “Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.
- (10) Protected Health Information. The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the Employer, that is transmitted or maintained in any form or medium.
- (11) Summary Health Information. The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals under the Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

GENERIC PLAN DOCUMENT HIPAA SECURITY LANGUAGE

Section 11B. Plan Document Provisions for Welfare Benefit Plans Required to Contain HIPAA Security Provisions.

HIPAA SECURITY COMPLIANCE

A. Preamble

This Appendix is made effective as of the date stated below, and modifies all group health plans maintained by **Employer Name** (“Employer”) and on account of which Employer is responsible for compliance with the Security Rules of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). For simplicity, these plan(s) are collectively referred to herein as the “HIPAA Plan(s)”. This Amendment is being made to allow the Employer to create, receive, maintain or transmit Electronic Protected Health Information (“ePHI”) in certain circumstances on behalf of its HIPAA Plan(s).

B. Effective Date

This Appendix is effective on the later of April 20, **2006** or the date upon which HIPAA compliance is required for the HIPAA Plan(s). This date is referred to as the “Effective Date.”

C. Safeguards

The Employer will put into place and follow Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI that the Employer creates, receives, maintains or transmits on behalf of the HIPAA Plan(s), except as stated in Section 1.7 below.

D. Adequate Separation

The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to Access or use such ePHI for the proper administration of the Employer’s HIPAA Plan(s), or for such other reasons as may be proper under HIPAA Security Rules. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such Security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them.

E. Control of Agents and Subcontractors

The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the HIPAA Plan(s), agrees to implement reasonable and appropriate security measures to protect the ePHI.

F. Reporting Security Incidents

The Employer will report to the HIPAA Plan(s) any Security Incident of which it becomes aware.

G. Exceptions

The terms of this HIPAA Security Appendix shall not apply if ePHI is disclosed to the Employer pursuant to an Authorization which meets the requirements of the HIPAA Privacy Rules described at 45 CFR § 164.508, or if the ePHI is Summary Health Information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the HIPAA Plan(s); or (b) to amend or terminate any of the HIPAA Plan(s). In addition, the terms of this HIPAA Security Appendix shall not apply if the ePHI disclosed to the Employer is information concerning whether an Individual is participating in any of the HIPAA Plan(s), or is enrolled or disenrolled from a health insurance issuer or HMO offered by any of the HIPAA Plan(s).

H. Definitions

- (1) Access “Access” means the ability or the means necessary to read, write, modify or communicate data/information or otherwise use any system resource.
- (2) Administrative Safeguards “Administrative Safeguards” are administrative actions and policies and procedures, to manage the selection, development, implementation and maintenance of security measures to protect Electronic Protected Health Information, and to manage the conduct of the HIPAA Plan(s) or their workforce in relation to the protection of that information.
- (3) Electronic Protected Health Information “Electronic Protected Health Information” or “ePHI” is Protected Health Information which is transmitted by Electronic Media or maintained in Electronic Media. For this purpose the term “Electronic Media” means (a) electronic storage media, including memory devices and computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disc, optical disc or digital memory card; or (b) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including transmissions of paper, via facsimile and of voice, via telephone, are not considered to be transmissions

via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

- (4) Health Information “Health Information” means any information, whether oral or recorded in any form or medium, that:
 - (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and
 - (b) relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.
- (5) HIPAA Privacy Rule or Rules The terms “HIPAA Privacy Rule” or “HIPAA Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information published at 45 CFR Parts 160 and 164, subparts A and E.
- (6) Individual An “Individual” is the person who is the subject of Protected Health Information.
- (7) Individually Identifiable Health Information The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.
- (8) Physical Safeguards “Physical Safeguards” are physical measures, policies, and procedures to protect the HIPAA Plan(s)’ electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.
- (9) Protected Health Information The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the employer, that is transmitted or maintained in any form or medium.
- (10) Security Incident A “Security Incident” means an attempted or successful unauthorized Access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
- (11) Security Rule or Rules Means the Security Standards for the protection of Electronic Protected Health Information published at 45 CFR Parts 160 and 164, subparts A and C.

- (12) Summary Health Information The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals under the HIPAA Plan(s), and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
- (13) Technical Safeguards “Technical Safeguards” mean the technology and the policies and procedures for its use that protect Electronic Protected Health Information and control Access to it.

Section 12: Family Medical Leave Act (FMLA)

A. Compliance

When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health expense coverage. If the Employer/Plan Sponsor is subject to the law and you are covered under health benefit plans, you may be able to continue your coverage under our benefit Plan for a certain period of time.

B. Benefits

To the extent required under the FMLA, and the regulations thereunder, an employee on FMLA leave of absence may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA, and the regulations thereunder, any employer contributions made under the terms of the Plan shall continue to be made on behalf of an employee on an FMLA leave.

Section 13: Life and Disability Insurance

Life Insurance and disability benefits, if applicable, are not subject to the COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion privilege may be exercised within 31 days following the date of termination. If you wish to exercise this conversion, please refer to your Certificate of Coverage for specific requirements.

Section 14: Not an Employment Contract

None of the plans or benefits discussed on the preceding pages are to be considered contracts for employment between the Employee and the Employer. The Plans do not guarantee the Employee

the right of continued employment nor do they limit the Employer's right to discharge any Employee.

Section 15: Plan Provisions Relating to Acts of Third Parties

If a participant or beneficiary is sick or injured as a result of the act or omission of another person or party, the participant or beneficiary, as a condition of receiving benefits under the Plan, must agree to reimburse the Plan for those benefits from all recoveries from a third party or parties, whether the recovery occurs by lawsuit, settlement, or otherwise. Further, the participant or beneficiary (or anyone acting on his or her behalf) shall hold all such amounts owed to the Plan in trust for the Plan upon receipt, and the Plan shall be entitled to a constructive trust and an equitable lien on any such proceeds as soon as the third party agrees to pay such amounts, or as soon as they are received by the participant, beneficiary, or anyone acting on his or her behalf. The participant and/or beneficiary agrees to cooperate in any way with the Plan in order to perfect such trust or equitable lien. The Plan's share of the recovery shall not be reduced by any attorney fees or court costs of the participant or beneficiary, or because the participant or beneficiary has not received the full damages claimed, unless the Plan agrees in writing to a reduction. In particular, any state "make whole" or "full recovery" laws or similar laws shall not apply to the Plan or its rights hereunder.

IN WITNESS WHEREOF, the Employer/Plan Sponsor caused this Welfare Plan Summary Plan Description and Plan Document to be executed effective on the ____ day of _____, 200__.

[EMPLOYER]

By: _____

Title: _____

Date: _____