



Schedule of Benefits

**For a more detailed explanation of benefits, please refer to your
HPA Summary Plan Description**

Restated: July 1, 2010

**HEALTHCARE PURCHASING ALLIANCE (HPA)
EMPLOYEE HEALTHCARE BENEFITS**

Restated July 1, 2010

Plan Sponsored By: Daytona State College

TO OUR ELIGIBLE EMPLOYEES:

Welcome. By electing to participate in this Plan, you have put quality, dependability and experience on your side. Benefits are big news these days, especially health care benefits. As health care costs continue to rise, your health care coverage becomes even more critical. This Plan has been designed to provide you and your family with both comprehensive and affordable coverage.

Please read the following pages carefully. Some of the words used in this booklet begin with a capital letter. These words are defined in the Definitions section. When reading this booklet, it may be helpful to refer to this section. Familiarize yourself with the Benefits available, then use the Plan to meet your needs; but use it wisely.

YOUR MEDICAL BENEFITS..... WHAT YOU SHOULD KNOW

You have enrolled under the Healthcare Purchasing Alliance (HPA) Employee Healthcare Benefits Plan. The Plan has contracted with a managed care network or networks of medical providers whose members have agreed to charge the Plan reduced or discounted charges for covered services provided to Covered Persons. Although you have the freedom to choose to receive care from any Physician, Hospital, or other medical care provider, as a general rule ***the amount or percentage of an otherwise Covered Expense payable by the Plan will vary, depending on whether the provider from whom you receive your care is a member of the Plan's PPO network(s).*** Generally, the Plan will pay a higher percentage of a Covered Expense if the care is received by a network provider. Thus, in order to receive the highest Benefit level, medical services and supplies should be received from a network provider.

Your Employee Health Care Plan ID card contains a toll-free phone number and/or a website you can use to obtain information about the health care providers who are members of the provider network(s).

WHO TO CONTACT

Healthcare Purchasing Alliance (HPA)

FMH group No: DS0000

Benefit, Eligibility and Claims Information

FMH CoreSource (866) 500-5048
Website: www.f-m-h.com/hpa

Provider Networks

Volusia Health Network (VHN) (386) 425-4846
Website: www.myvhn.com

Florida Memorial Health Network (FMHN) (386) 615-4398 or (888) 839-7430
Website: www.fmhn.org

Florida Hospital Healthcare System (FHHS) (800) 741-4869 or (407) 741-4869

Provider Network for members living outside of the VHN/FMHN network service area

Private HealthCare Systems Network (PHCS) (866) 297-9122
Website: www.multiplan.com

Pharmacy Network

MedTrak Pharmacy Services (800) 771-4648
MedTrak SpecialtyRx (800) 771-4648
Website: www.medtrakrx.com

PRE-CERTIFICATION **Disease and Utilization Management** **(MEDICAL SERVICES ONLY)**

KePRO (formerly PPHA) (888) 522-7742
24-hour Nurse Help Line (877) 582-7061

Mental & Behavioral Health/Substance Abuse – for all outpatient care

Horizon Health (800) 272-7252
Website: www.horizoncarelink.com

Chiropractic Network - DPSC

Provider Inquiry Information (386) 615-0801

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All Benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but limited to, the Plan Administrator's determination that:

- care and treatment is Medically Necessary;
- charges are Usual and Reasonable;
- services, supplies and care are not Experimental, Investigational or Unproven Services.

Deductibles/Co-payments Payable by Plan participants

Deductibles, Co-payments and Co-insurance are dollar amounts that the Covered Person must pay before this Plan pays. Each July 1st, a new deductible amount is required.

A Co-payment or Co-insurance is a smaller amount of money that may be paid each time a particular service is used.

Participating Provider Organization (PPO) Plan

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care providers, which are called participating providers.

The PPO organizations this Plan has contracted with for the In-Network Level of Benefits are:

- Volusia Health Network
- Orlando Health
- Florida Memorial Health Network
- Florida Hospital Health Systems
- Doctor's Professional Services Consultants
- Horizon Health

The PPO organization this Plan has contracted with for members living outside the VHN/FMHN network service area for the In-Network Level of Benefits is:

- PHCS Network (Private HealthCare Systems)

Therefore, when a Covered Person uses a participating provider, that Covered Person will receive the higher in-network level of Benefits from this Plan than when a non-participating provider (Out-of-Network) is used. It is the Covered Person's choice as to which provider to use.

A list of participating providers will be made available to covered Employees and updated on a regular basis.

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
	Deductible and Co-insurance Apply Except as Provided:	
Services Rendered by Radiology Associates Imaging Centers	90% (Deductible waived)	
Neurology & Pain Relief, LLC Office Visit	100% after \$35 Co-pay (Deductible waived)	50%
All Other Services	90%	50%
Diagnostic X-Rays, Imaging and Laboratory Services Inpatient, Outpatient and Independent Lab	80%	50%
Physician Services		
Primary Care Office Visit Includes (GYN/OB, Pediatrician, Internal Medicine)	100% after \$20 Co-pay (Deductible waived)	50%
Specialist Office Visit	100% after \$35 Co-pay (Deductible waived)	50%
<i>All Other Services rendered at time of visit</i>	80%	50%
Allergy Shots and Testing		
Injections	100% (Co-pay & Deductible waived)	50%
Testing and Serum	80%	50%
Inpatient Hospital Care	80%	50%
Note: Pre-Certification by KePRO (formerly PPHA) required		
Outpatient Services	80%	50%
Note: Pre-Certification by KePRO (formerly PPHA) required for certain Surgical and Medical Services		
Ambulance	80% After In-Network Deductible	
Emergency Room¹	80%	50%

¹ Coverage for emergency room treatment at an Out-of-Network Hospital for conditions that meet the definition of Emergency, payment will be considered at the In-Network level for Covered Expenses received in the emergency room. If you are then admitted to the Out-of-Network Hospital, Covered Expenses for Hospital and Physician services will be considered at the In-Network level until Your Attending Physician determines it is medically appropriate for You to be transferred.

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
Deductible and Co-insurance Apply Except as Provided:		
PrimeCare Urgent Care Centers		
Urgent Care Visit	100% after \$20 Co-pay (Deductible waived)	N/A
<i>All Other Services rendered at time of visit</i>	80%	N/A
Urgent Care Services	80%	50%
Note: If the choice of Hospital and/or Physician was beyond the control of the Covered Person, then all Urgent Care services rendered for a Medical Emergency will be payable at the In-Network level of Benefits		
WELLNESS CARE		
Note: <i>The Wellness maximum of \$250 <u>applies only</u> to the Wellness Care Benefit for Age 17 and over and <u>does not</u> apply to Well Child/Well Baby or Well Woman Care. Once \$250 maximum is exhausted, there is no Benefit until the next Plan Year.</i>		
Wellness Care (Age 17 and over) <i>\$250 Max. per Covered Person per Plan Year</i> Coverage Includes: Routine Physical Exam Hearing Exam PSA Exam and related Labs Colon Exam (Sigmoidoscopy and related services and related Labs) X-rays / Labs Immunizations and Inoculations Bone Density Study (Age 45 and over)	100% (Co-pay & Deductible waived)	Not Covered
Note: <i>Benefit sponsored activities approved by HPA, such as flu shots, will be payable at 100% (Deductible waived) for eligible Covered Persons. These Benefits <u>will not</u> apply to the \$250 Wellness Care Plan Year Maximum. Health Risk Appraisal and accompanying annual blood draw will be payable at 100% by the Plan (Deductible waived) when pre-certified through KePRO (formerly PPHA) once per Plan Year. These Benefits will not apply to the \$250 Wellness Care Plan Year Maximum. Any additional wellness-related blood draws during the Plan Year will be subject to the Wellness Care Benefit.</i>		
Well Child/Well Baby Care (Age 16 and under) <i>Limited to 18 visits Max. through Age 16</i> Coverage Includes: Routine Physical Exam Hearing Exam Developmental Assessment Labs Immunizations	100% (Co-pay & Deductible waived)	Not Covered

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
Deductible and Co-insurance Apply Except as Provided:		
Well Woman Care Coverage Includes: Gynecological or Contraceptive Exam (1 Exam per Plan Year) Pap smear (1 Exam per Plan Year) Contraceptive Injectables (i.e. Depo Provera)	100% (Co-pay & Deductible waived)	Not Covered
Mammogram Routine or Medically Indicated limited to: Age 35-39: 1 Baseline Age 40 and over: 1 per Plan Year Medically indicated mammogram diagnosed from the initial mammogram	100% (Co-pay & Deductible waived) 80%	50% 50%
Colonoscopy Routine or Medically Indicated limited to: Age 50 and over: 1 per covered member, 1 every ten (10) years thereafter (Includes Prep Kit and Supplies) Medically indicated colonoscopy diagnosed from the initial colonoscopy	100% (Deductible waived) 80%	50% 50%
Maternity Initial Physician Office Visit Physician Delivery Charge Hospital Charges	100% after \$20 Co-pay (Deductible waived) 100% after \$250 Co-pay (Deductible waived) 80%	50% 50% 50%
Organ Transplants Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Second Opinion	100% after \$35 Co-pay (Deductible waived)	50%
Skilled Nursing Facility Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Home Health Care Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
	Deductible and Co-insurance Apply Except as Provided:	
Hospice Care Including Bereavement Counseling	80%	50%
Inpatient Rehabilitation Facility Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Physical, Occupational, Speech and Massage Therapy Inpatient, Outpatient and Physician Office Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Chiropractic Care 12 visit Max. per Plan Year	80%	50%
Note: Visits exceeding the initial 12 visit Max. per Plan Year must be approved by Doctors Professional Services Consultants (DPSC)		
Mental and Nervous/Substance Abuse		
Inpatient	80%	50%
Outpatient (including Partial Hospitalization)	80%	50%
Office	100% after \$20 Co-pay (Deductible waived)	50%
Note: Inpatient requires pre-certification through KePRO (formerly PPHA). Outpatient (including Partial Hospitalization) must be pre-certified through Horizon Health. Call Horizon Health at: 1-800-272-7252		
Durable Medical Equipment Except for diabetic supplies, which are covered through MedTrak Pharmacy Services Note: Pre-Certification by KePRO (formerly PPHA) required if over \$250	80%	50%
Infertility Treatment \$2,000 Max. per Lifetime for Diagnostic services only	80%	50%
Wigs Limited to the initial purchase after Chemotherapy or when diagnosed with Alopecia Areata	80% After In-Network Deductible	
Nutritionist Limited to treatment of Diabetes and Heart Disease	80%	50%

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PRESCRIPTION DRUG CO-PAYS

Generic Provision Difference

If a generic equivalent of a prescription Drug is available and the Covered Person chooses the brand name over the generic equivalent, then he or she must pay the cost difference between the generic and brand name Drug in addition to the Co-pay.

Covered Benefits	In-Network
Retail Network (30-day supply):	
Generic (preferred):	\$10
Brand Name (preferred):	\$30
Brand Name (non-preferred):	\$60
MedTrak 90 (90-day supply):	
Generic (preferred):	\$20
Brand Name (preferred):	\$60
Brand Name (non-preferred):	\$120
Mail Order (90-day supply):	
Generic (preferred):	\$20
Brand Name (preferred):	\$60
Brand Name (non-preferred):	\$120
Note: In order to maximize your prescription Drug Benefit, you may utilize either the MedTrak 90 Program or the Mail Order option by obtaining a prescription for a 90-day supply from your Physician.	
Specialty Drugs	20% up to \$60 with a plan year out of pocket maximum of \$2,000

A Specialty Drug is only available in a 30-day supply and must be obtained through the pharmacy benefit manager's Specialty Drug program in order to be a covered Benefit. See the section titled, Covered Expenses, for details.

DENTAL BENEFITS	
Deductible (per Plan Year)	
Individual	\$50
Family	\$150
Benefit Plan Percentages:	
Class I – Preventive (including: oral exams, x-rays(adults), 2 cleanings per Plan Year and fluoride treatment (up to age 19))	80% Deductible waived
Class II – Basic (including: fillings, extractions, periodontics, endodontics and root canals)	80% after Deductible
Class III – Major (including: crowns, bridges and dentures)	50% after Deductible
Class IV – Orthodontia / Implants	50% after Deductible
Maximums	
Class I , II and III per person per Plan Year	\$1,000
Class IV Orthodontia and Implants, per person per Lifetime	\$1,000

Please refer to the Dental section of your HPA Summary Plan Description for detailed explanation of your Dental Benefits.

VISION BENEFITS	
Deductible (Per Plan Year)	None
Eye Exam (including refractions) Per Covered Person per Plan Year	100% up to \$50
Framed Lenses (In lieu of Contact Lenses or Disposable Lenses) One (1) pair per Plan Year	
Single Vision	100% up to \$25 per pair
Bi-focal	100% up to \$25 per pair
Tri-focal	100% up to \$32.50 per pair
Lenticular	100% up to \$32.50 per pair
Progressive	100% up to \$32.50 per pair
Frames One (1) pair every 24 month period	100% up to \$100
Contact Lenses (In lieu of frames and lenses or Disposable Contact Lenses) Per Covered Person per Plan Year	100% up to \$100
Disposable Contact Lenses (In lieu of frames and lenses or Contact Lenses) Per Covered Person per Plan Year	100% up to \$100
<p>Note: The Plan will only cover the purchase of one (1) of the following per Plan Year.</p> <ul style="list-style-type: none"> • Contact Lenses, Disposable Contact Lenses, or Lenses for glasses <p><i>Replacement lenses, frames, or contact lenses are not covered under this Plan.</i></p>	

Please refer to the Vision section of your HPA Summary Plan Description for detailed explanation of your Vision Benefits.

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE

KePRO (formerly PPHA) provides utilization management of medical care for the Healthcare Purchasing Alliance (HPA) Plan. Utilization management includes pre-certification of selected medical services to establish medical necessity and the appropriate level of care.

Pre-certification of the medical services, including Mental Health and Substance Abuse, listed below is mandatory. It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify before services are rendered will result in a possible denial of Benefits or the following penalties (not to exceed covered charges):

Inpatient - \$1,000 per admission
Outpatient - \$250 per occurrence

The medical services listed below must be pre-certified by calling:

KePRO (formerly PPHA)
(888) 522-7742

Horizon Health
(800) 272-7252

1. All Inpatient Care

- Observation care lasting more than 23 hours
- Emergency admissions must be reported to KePRO (formerly PPHA) within 24 hours or the next Business Day after the admission

Notwithstanding the foregoing, this Plan will not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. In addition, the Plan shall not require a Hospital, Physician or other medical provider to obtain authorization or pre-certification from the Plan Sponsor or its medical review specialist for prescribing any length of stay described above. However, these rules shall not apply where the decision to discharge the mother or her newborn Child prior to the expiration of the minimum length of stay periods described above is made by the mother's or Child's Attending Physician in consultation with the mother.

2. Outpatient Surgical and Medical Services

- Adenoidectomy
- Colonoscopy - under age 50
- Durable Medical Equipment - **over \$250**
- Durable Medical Equipment Repair or Replacement
- Home Health Care
- Hyperbaric Oxygen Treatments
- Nasal Surgery (includes nasal endoscopy, rhinoplasty, and septoplasty)
- PET Scans
- Prophylactic Surgery (for the prevention of breast and ovarian cancer)
- Reduction Mammoplasty
- Sleep Apnea Studies
- Therapies: Massage, Occupational, Physical, Radiation, and Speech
- TMJ/CMJ Surgery
- Tonsillectomy
- Varicose Vein Excision and Ligation

3. Specialty Drugs

- Specialty Drugs require pre-certification through MedTrak Pharmacy Services

If you have been admitted on an Emergency or maternity basis, the medical review specialist must be notified within 48 hours of the admission.

4. Mental Health and Substance Abuse

All Inpatient Care

- Emergency admissions must be reported to KePRO (formerly PPHA) within 24 hours or the next Business Day after the admission.

Outpatient Services (including Partial Hospitalization)

- Failure to pre-certify may result in the application of a \$250 penalty or possible denial of Benefits.

The Plan has the absolute authority to waive the normal provisions of the Plan if Horizon Health or KePRO (formerly PPHA) submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice to quality of patient care and is no more expensive than regular Plan Benefits would be.

Horizon Health also provides free Employee Assistance Program (EAP) services 24 hours a day to all Employees and their family members, as well as pre-certification and authorization of Mental and Nervous Disorders and Substance Abuse Treatment Benefits under this Plan.

EAP Services provide short-term counseling for any problem which affects your well-being or ability to perform at work. Examples include stress, family or marital problems, Substance Abuse, financial or legal difficulties, or emotional problems. By using the EAP free services, you may avoid having to use costly Mental and Nervous Disorders and Substance Abuse Treatment altogether. Call Horizon Health at (800) 272-7252 for complete details.

CASE MANAGEMENT. In a case where your condition is expected to be or is of a serious nature, the Plan Sponsor may arrange for review and/or case management services from a professional qualified to perform such services. Based on the review, the Plan Sponsor shall have the right to alter or waive the normal provisions of the Plan, including Benefit limits, when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. For example, if you require Custodial Care rather than Inpatient Hospital care, but the Plan does not cover Custodial Care and, as a result, the only practical alternative covered by the Plan is Inpatient Hospital care, the Plan may agree to treat your Custodial Care expenses as Covered Expenses in lieu of having you remain or re-admitted as a Hospital Inpatient, where doing so is cost effective to the Plan and does not compromise the quality of your care. This provision shall also operate to the extent required by any reinsurance contract between the Plan Sponsor and the reinsurer.

PREVENTIVE SERVICES

This Plan may cover annual physical examinations for eligible Covered Employees, Covered Spouses, and Covered Dependent Children. Well woman services are provided for eligible Covered Employees, Covered Spouses, and Covered Dependent Children.

Preventive Services are not subject to the Plan Year deductible.

Annual Physical Examinations

Annual routine physical exams are covered each Plan Year when using a Preferred Provider Physician.

The \$250 Maximum Annual Routine Physical Benefit includes and is limited to, the following services:

- Physical examinations and history
- EKG
- Laboratory tests
- Hemocult
- Urinalysis
- X-Rays*
- Bone density study – age 45 and over*
- Hearing screening
- Sigmoidoscopy
- PSA Blood Test
- Inoculations and immunizations
- Prostate exam

***Services rendered by Radiology Associates Imaging Centers are available at deeper discounts, which will help you maximize the use of your wellness benefit.**

All charges in excess of the \$250 maximum are the patients' responsibility and do not track toward the annual Out-of-Pocket Maximum or the deductible.

Health Risk Appraisal and accompanying annual blood draw may be payable at 100% by the Plan (Deductible waived) when pre-certified through KePRO (formerly PPHA) once per Plan Year. These Benefits will not apply to the \$250 Wellness Care Plan Year Maximum. Any additional wellness-related blood draws during the Plan Year are payable at Deductible and Co-insurance.

Well Woman Services

Covered Benefits include per Plan Year one mammogram, contraceptive injectables (i.e., Depo-Provera), and an annual pelvic examination with pap smear.

Well Child Care Services

The Plan covers certain well child care services provided by a Physician from the moment of birth through age sixteen. The Plan allows for a maximum of 18 visits during that time period.

The covered services for each visit to the Physician include: a history, anticipatory guidance, physician examination, appropriate immunizations, hearing exams, developmental assessment, and laboratory tests in keeping with prevailing medical standards.

ARTICLE I INTRODUCTION

This is the Plan Document. It also represents what is referred to as a Summary Plan Description. It describes the Benefits to which you and your covered Dependents are entitled, to whom Benefits are payable and other provisions, which govern or control the way in which Benefits are provided.

PLAN SPONSOR. The Plan Sponsor is **Daytona State College**. The Plan Sponsor has the authority to control and manage the operation and administration of the Plan; to establish Plan Benefits and provisions; to amend the Plan; to determine its policies; to appoint and remove the Claim Supervisor, and to exercise general administrative authority over the Supervisor.

CLAIM SUPERVISOR. The Claim Supervisor of the Plan is **FMH CoreSource**.

CONTRIBUTIONS TO THE PLAN. The Employer makes contributions to the Plan so that the Plan may make Benefit payments to you and your Dependents. You may also be required to make contributions to the Plan for your coverage or for coverage of your Dependents, or for both you and your Dependents' coverage. For more information concerning the funding of this Plan, see the section titled, *General Information--Funding Method*.

CLAIM PROCEDURES. Claim payments are made based on data furnished by you or your health care provider. In order to collect Benefits under the Plan, you or the provider must first provide information as to the validity of the claim for Benefits. For ease of administration, you may have to file a "claim form" for You and Your Dependents. This form contains essential information necessary for the Claim Supervisor to determine the validity of a claim for Benefits. Occasionally, further information may be necessary and you should provide this information to the Claim Supervisor as requested.

CLAIM DETERMINATION. A determination regarding payment of eligible Benefits will normally be made within 30 days from the Claim Supervisor's receipt of all necessary information regarding the claim for Benefits. All interpretations of the Plan's terms regarding Benefits will be made by the Plan Sponsor.

CLAIM FILING DEADLINE. A claim will not be considered unless it is filed within twelve (12) months after the date on which the expense is incurred. Terminated Employees (and their Dependents) must file all incurred but unfiled claims within twelve (12) months after the date of termination of their coverage. In the event of the Plan's termination, you must file all incurred but unfiled claims within twelve (12) months after the Plan's termination.

See the section of this booklet titled, *Claim Filing Procedures*, for more information about your rights with respect to claims and appeals of determinations that are made with respect to claims.

ARTICLE II ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for you and your Dependents will be in accordance with the eligibility, Effective Date and termination provisions that follow below.

EMPLOYEE ELIGIBILITY. In order to be eligible for coverage under this Plan you must be both an Employee and an *eligible* Employee. Generally, an *Employee* is a person employed by the Employer in a classification of employment that qualifies him for participation in the Plan and fulfilling their employment obligation as defined by the College. See the definition of “*Employee*” in the section of this booklet titled, *Definitions*. Generally, an *eligible* Employee is an Employee who has met any service requirements that the Employee must meet in order to become eligible. Those service requirements, if they apply, are described in the following paragraph.

DEPENDENT ELIGIBILITY. Your Dependents are eligible for coverage under the Plan on the date you become eligible for Employee coverage, or the date on which the Dependents become your Dependents, whichever occurs last. *However, under no circumstances may you enroll your Dependents if you are not also enrolled under the Plan.* If both you and your spouse are Employees, and both are eligible for Dependent coverage, either you or your spouse, but not both, may elect Dependent coverage for your other eligible Dependents (e.g., Dependent Children). No person may be covered under this Plan as both an Employee and as a Dependent. Dependent eligibility is also subject to the following rules:

Newborns. If you notify the Employer, in writing, of the birth of your newborn Child within thirty-one (31) days after the date of birth, coverage for the newborn becomes effective on the date of birth and any additional premium applicable to the newborn will be waived for the thirty-one (31) day notice period. If notice is given after thirty-one (31) days from the date of birth, but within sixty (60) days from the date of birth of the newborn Child, coverage for the newborn becomes effective on the date of birth only if any additional premium applicable to the newborn, from the date of birth, has been paid. If notice is not given within sixty (60) days from the date of the newborn Child, the covered Employee may not enroll the newborn in the Plan until the next annual open enrollment.

A newborn Child of a Covered Dependent Child is eligible to participate from birth up to age 18 months. Generally, coverage of newborn Children includes coverage for care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity; and for any routine nursery care provided under this Plan. See the description of Covered Expenses in the section of this booklet titled, *Covered Expenses*.

New Spouse. Your spouse will be considered an eligible Dependent the first of the month following the date of marriage, if you are an eligible Employee at that time and provide the Employee Benefits Department with a copy of your marriage certificate within 31-days of the date of marriage. Upon dissolution of the marriage, the now former spouse is no longer eligible for coverage as a spouse but may be offered COBRA (see section titled, *COBRA Continuation Coverage*).

Other New Dependents. If you acquire a Dependent (other than your spouse) due to marriage, legal adoption or legal guardianship, that Dependent shall be considered an eligible Dependent as of the date of such occurrence, if you are an eligible Employee at that time and you notify the Employer, in writing within thirty-one (31) days of that event. A Child will be considered adopted on the date the Child’s adoption becomes final or on the date the Child is placed for adoption (a Child is considered placed for adoption when you assume and retain a legal obligation for total or partial support of the Child in anticipation of adoption; the Child’s placement terminates upon termination of such legal obligation).

Continuing Coverage for Disabled Dependent Children. An unmarried Child who is a Dependent and who reaches the Plan’s limiting age for Dependent Children while covered under this Plan will remain eligible for coverage to the extent he is at that time incapable of self-sustaining employment and is dependent upon you for support due to a mental or physical illness or disability. He will remain eligible for coverage under this provision to the extent you remain eligible for Dependent coverage and he remains incapable of self-sustaining employment and dependent upon you for support due to the disability. Notification of incapacitation must be provided within thirty-one (31) days after the Child attains age 19. Proof of incapacitation may be required to determine whether or not the Child qualifies as disabled and may be required on an annual basis.

Qualified Medical Child Support Orders (QMCSO). The Plan will honor the terms of a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is an order that is typically issued in or after divorce proceedings, and may create or recognize the right of your Child to be covered under this Plan. Such an order must be qualified and issued by a court of competent jurisdiction or authorized state agency in order for this Plan to be bound by it. Please contact your Employee Benefits Department for more information regarding whether or not a medical child support order is “qualified”. That department will “process” the order as follows:

- Your Employer, promptly after receiving a medical child support order, will notify you of each Child designated in the order. The notification will contain information that permits the Child to designate a representative for receipt of copies of notices that are sent to the Child with respect to a medical child support order.
- Within forty (40) business days after receipt of the order (or, in the case of a national medical support notice, the date of the notice) the Employer will determine whether the order is a “qualified” medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Employer will send a written copy of the determination to you and each Child (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official).
- If the Employer determines that the medical child support order is qualified, you, the Child or his representative must furnish to the Employer any required enrollment information. In the case of a national medical support notice, the Employer will (i) notify the state agency issuing the notice whether coverage is available to the Child under the Plan and, if so, whether such Child is covered under the Plan and either the Effective Date of such coverage or any steps to be taken by the Child’s custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
- Typically you must provide such information to the Plan within forty-five (45) days immediately following the date the determination was made that the order was a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the Child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Employer’s notice described in the preceding paragraph, the Child will be enrolled under the Plan’s default option (if any).
- Unless the Qualified Medical Child Support Order provides otherwise, you will be responsible to make any required contribution to pay for such coverage.
- In no event will coverage provided under a Qualified Medical Child Support Order become effective for a Child prior to the date the Order is received by the Plan.
- If the Employer determines that the medical child support order is not “qualified”, a written determination to that effect will be furnished to you and the Child or the Child’s representative. You or the Child (or the Child’s representative) may appeal the determination to the Employer. Any request for review of a determination must be filed with the Employer within sixty (60) days after the Employer issues its original determination.

ARTICLE III EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE. Your coverage is effective as follows:

Enrollment when first eligible. If you complete and file with us the required enrollment forms no later than 31 days after the date you first become eligible, coverage will be effective the first of the month following one month of employment. For example, if you are hired on April 16th, coverage begins on June 1st. If your coverage Effective Date is later than the date you became eligible, you must still be eligible on your coverage Effective Date in order for coverage to begin.

Late Enrollment. If you decline to enroll within the first 31 days after you initially become eligible, you may enroll thereafter only by completing and filing with us the required enrollment forms either (1) within 31 days after experiencing a special enrollment event (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), (as described below in the section titled, *Special Enrollment Events*), or (2) during the Plan's annual enrollment period.

If you enroll within 31 days after a **special enrollment event**, (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009) the date your coverage is effective depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption or placement for adoption, your coverage is effective as of the date of that event. If the event is loss of other coverage or your acquisition of a Dependent by virtue of marriage, your coverage is effective not later than the first day of the month following the month in which you file the required enrollment forms with us. In either case you must be eligible for coverage on the date your coverage would become effective.

If you enroll during the annual enrollment period, your coverage will be effective at the beginning of the new Plan Year (provided you are then still eligible).

DEPENDENT EFFECTIVE DATE.

Enrollment when first eligible. If you are already enrolled for Dependent coverage at the time you acquire a Dependent, coverage of the Dependent is effective on the date the Dependent became an eligible Dependent. In other cases, you must complete and file with us the required enrollment forms no later than 31 days after the date your Dependent first becomes eligible, in which case coverage of the Dependent will be effective at 12:01 a.m. on the first of the month coinciding with the date application is made (where the eligible Dependent is a newborn Child, coverage will be effective as of the date of birth, if this date is different than the date described above), provided your coverage is then in effect.

Late Enrollment. If you decline to enroll within the first 31 days after you initially become eligible, you may enroll thereafter only by completing and filing with us the required enrollment forms either (1) within 31 days after experiencing a special enrollment event (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), as described below in the section titled, *Special Enrollment Events*, or (2) during the Plan's annual enrollment period.

You may also enroll the Dependent during the Plan's annual enrollment period.

If you enroll within 31 days after a **special enrollment event** (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), the date your coverage is effective depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption or placement for adoption, your coverage is effective as of the date of that event. If the event is loss of other coverage or your acquisition of a Dependent by virtue of marriage, your coverage is effective as the date of marriage if you file the required enrollment forms with us within 31 days. In either case you must be eligible for coverage on the date your coverage would become effective

If you enroll during the annual enrollment period, your coverage will be effective at the beginning of the new Plan Year (provided you are then still eligible).

In all cases, we may require proof of dependency (and, in the case of an adopted Child or a Child placed with you for adoption, proof of the adoption or placement for adoption) as a condition to enrolling an eligible Dependent.

ENROLLMENT CHANGES UNDER FLEXIBLE BENEFITS PLAN. In addition to the changes in enrollment elections described above, you may also be eligible to change your enrollment election (to add, drop or change coverage for yourself, your Dependents, or both you and your Dependents) by changing your health coverage election under the Employer's flexible benefits plan, in accordance with the procedures described in that Plan.

SPECIAL ENROLLMENT EVENTS. For purposes of the enrollment rules described above, and/or for purposes of the Plan's Pre-Existing Condition restriction (if any), "special enrollment events" are:

Loss of Other Coverage. You or an eligible Dependent will be considered to have experienced this special enrollment event if:

- you or the eligible Dependent declined a previous opportunity to enroll or be enrolled under the Plan;
- at the time you or the eligible Dependent were previously offered the opportunity to enroll or to be enrolled you declined to enroll yourself (or, in case of an eligible Dependent, to enroll the eligible Dependent) because you had (or, in the case of an eligible Dependent, the eligible Dependent had) other health coverage; *and*
- that other coverage was either (1) COBRA Continuation Coverage which is now exhausted (other than for failure to pay premiums or for fraudulent behavior), or (2) non-COBRA Continuation Coverage under a group health plan or other health insurance which has been terminated due to loss of eligibility (other than for failure to pay premiums or for fraudulent behavior) or termination of employer contributions toward such other coverage. For this purpose, a "loss of eligibility" includes (but is not limited to) a loss of eligibility for coverage as a result of (i) divorce, (ii) cessation of Dependent status, (iii) death of an Employee, (iv) termination of employment, (v) reduction in hours, (vi) no longer residing or working in a required service area of the plan providing your coverage, (vii) a situation where you incur a claim that would meet or exceed a lifetime limit on all Benefits, or (viii) a situation where a plan no longer provides any Benefits to a class of similarly-situated individuals as yourself); (3) State Children's Health Insurance Program coverage; or (4) Medicaid coverage. Note: for both State Children's Health Insurance Program and Medicaid, Children or their parents have 60 days in which to request special enrollment under this Plan.
- switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's spouse.
- taking an unpaid Leave of Absence by the Employee or Employee's spouse.

Loss of eligibility includes but is not limited to:

- loss of eligibility for coverage as a result of ceasing to meet the Plan's eligibility requirements (i.e., divorce, cessation of Dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment);
- loss of coverage because the Covered Person no longer resides or works in the service area and no other coverage option is available through the plan providing your coverage;
- elimination of the coverage option a Covered Person was enrolled in, and another option is not offered in its place; and
- reaching the Plan's lifetime Benefit maximum on all Benefits, if the Covered Person is covered under a separate plan or a single plan with multiple options and the other option has a higher Lifetime Maximum, or the Benefits paid under the first option were not integrated with the second option.

For purposes of determining whether you had "non-COBRA Continuation Coverage" as described above, the term "group health plan" means a plan maintained or contributed to by an employer or employee organization (e.g., a union) to provide health care for employees and their families. The term "other health insurance" means benefits consisting of medical care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract or HMO contract, by an insurance company, service, or organization required to be licensed to engage in the business of insurance in a state and that is subject to state insurance law. Specifically, "other health insurance" does not include coverage under Medicare or Medicaid.

Change in Status

If, as a result of a change in status, an Employee has the right to add additional coverage, then the Employee will have 31 days after the date of the event that constituted the change in status to notify the Plan of his or her new

election. If an Employee fails to notify the Plan within this 31-day period, the Employee would not be eligible to apply for the additional coverage until the next annual enrollment period.

Following are valid status changes:

- The legal marriage or divorce of an Employee;
- The death of the Employee's Dependent;
- The birth or adoption of a Child of the Employee;
- The termination or commencement of employment of Employee's spouse;
- The switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's spouse;
- The taking of an unpaid leave of absence by the Employee or Employee's spouse; or
- A significant change occurs in the health coverage of the Employee or spouse attributable to the spouse's employment.

If, as a result of a change in status, an Employee has the right to reduce coverage (or if coverage is automatically reduced under the Plan), the Employee will have 31 days after the date of the change in status to notify the Plan of his or her election to reduce coverage. If the Employee notifies the Plan within this 31-day period, the change of coverage will apply the last day of the month in which your status change is approved.

Credit for any over deductions will only be reimbursed back to the date of written notification to the Plan. Employees cannot add, drop, or change coverage except during the annual open enrollment period or within 31 days of a change in status.

Acquisition of a Dependent by Virtue of Marriage, Birth, Adoption or Placement for Adoption. This special enrollment event occurs where you acquire a Dependent spouse or Child by virtue of marriage, or you acquire a Dependent Child by virtue of birth, adoption or placement for adoption.

Premium Assistance. This special enrollment event occurs where an eligible Child (and, under certain circumstances, the Child's parent-Employee) becomes eligible for premium assistance through State Children's Health Insurance Program or Medicaid. Children or their parents have 60 days in which to request special enrollment under this Plan.

Note that, in connection with enrolling under a "special enrollment event", you may be able to switch coverage options if the Employer offers more than one coverage option to you.

CHANGES IN COVERAGE. Should you change classifications which results in a coverage change, or should Benefits under this Plan be increased by a Plan change, the Effective Date of such change shall coincide with the date of the Benefit or classification change; however, if you are not actively at work, for reasons other than a health status-related reason, on the date the amount of your coverage would otherwise increase, such increase shall not become effective until the next following day on which you are actively at work.

Should Benefits under this Plan be decreased or deleted, the Effective Date of change will be the Effective Date of the decrease or deletion.

ARTICLE IV TERMINATION OF COVERAGE

TERMINATION OF COVERED EMPLOYEE'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as an Employee will terminate on the earliest of the following dates:

- If you fail to remit required contributions for your coverage when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month in which you are no longer an Employee.
- The last day of the month in which your employment in an eligible class ceases; employment is considered to cease on the last day worked within the eligible class.
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period, subject to the requirements of the Uniformed Services Employment and Reemployment Rights Act or similar applicable federal laws.
- The date the Plan is terminated.
- The last day of the month in which you request your coverage to be terminated (subject, however, to any limitations, under an affiliated cafeteria plan under Section 125 of the Internal Revenue Code, on your right to change coverage elections prior to the end of the Plan Year).
- The date the Plan Sponsor determines, in its sole discretion, that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan's Lifetime Maximum; provided, however, that you may choose to maintain your enrollment in the Plan notwithstanding the fact that you have reached the Plan's Lifetime Maximum (for example, you may wish to choose to maintain your enrollment so that the coverage of your Dependent(s) can continue under the Plan).

TERMINATION OF COVERED DEPENDENT'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as a covered Dependent will terminate on the earliest of the following dates:

- The date your sponsor's (the eligible Employee's) coverage terminates.
- If required contributions for your coverage are not remitted when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month in which you cease to be in a class eligible for Dependent coverage.
- The last day of the month in which you cease to meet the definition of a *Dependent*; except that if you fail to meet the definition of *Dependent* due merely to attainment of the Plan's limiting age for Dependent Children, the termination Effective Date described in the definition of *Dependent*, in the section titled, *Definitions*, will control.
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period.
- The last day of the month in which you become covered as an Employee.
- The date Dependent coverage is discontinued under the Plan.
- The date the Plan is terminated.
- The date the Plan Sponsor determines, in its sole discretion that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan's Lifetime Maximum.
- The date the Employee disenrolls a Child and enrolls that Child in a State Children's Health Insurance Program.

CELTIC MEDICAL CONVERSION PROGRAM. Coverage for you or your Dependents should terminate under the Plan, a conversion coverage option may be available. Check with your Employer for details of current conversion options at the time coverage terminates.

If coverage under this Plan terminates, participants may be eligible to purchase a conversion policy on an individual basis. Application must be made within 31 days of the date the group coverage terminates. Rules governing this purchase are established by the insurance carrier contracted to provide such services. All details concerning this policy will be furnished upon request.

EXCEPTIONS TO TERMINATION PROVISIONS - EXTENSION OF ACTIVE SERVICE (DURING ABSENCE FROM EMPLOYMENT). If your coverage as an eligible Employee would otherwise terminate due to termination of your active service due to a reason described below, your coverage may nevertheless continue (so long as the Plan remains in force) for a period of time.

In the case of an **approved full or partial paid leave of absence**, your coverage may continue up to the date your leave of absence terminates, or to the date that is twelve months after the date the leave of absence began. Premiums, which are the responsibility of the Employee, shall remain their responsibility.

In the case of an **unpaid leave of absence**, your coverage terminates. COBRA Continuation of Coverage is available with full premiums paid at the applicable rate.

In the case of your **Total Disability**, your coverage may continue for up to twelve months after the date the Total Disability begins.

Eligibility for coverage continued under this provision is in addition to coverage continued under the Plan's Continuation Coverage provisions except where the event giving rise to the continued eligibility would but for this provision be a "qualifying" or other event entitling you to continued coverage. In that latter case, the extended eligibility may run concurrently with the continued coverage. See also the Plan's Continuation Coverage rules that may apply in the case of leave, which is taken under the Family and Medical Leave Act, or in the case of certain uniformed service. These rules are described in the section of this booklet titled, *COBRA Continuation Coverage*.

OTHER METHODS OF CONTINUING COVERAGE

Family and Medical Leave Act

Regardless of the established leave policies of the Employer, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as outlined in the regulations issued by the Department of Labor, to the extent that Act applies. For an Approved Leave of Absence for 12 Weeks or less, coverage paid by the College continues as if you are an active Employee. Dependent premiums and Employee Co-Payments are paid directly to the Employee Benefits Department.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

You may have certain rights to continue or reacquire coverage if you engage in periods of uniformed service, and satisfy certain requirements upon the completion of that service. Your Plan Sponsor has additional information about these special rules. Regardless of the Employer's established Leave of Absence policies, this Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act for Covered Employees going into or returning from military service.

For Employees electing coverage prior to December 10, 2004, these rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in this Plan upon return from service. For Employees electing coverage on or after December 10, 2004, will receive up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in this Plan upon return from service. If, however, the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

For additional information concerning the USERRA, including your rights and responsibilities under the Act, please contact the Employee Benefits Department.

CREDITABLE COVERAGE CERTIFICATES. When your coverage under this Plan terminates, as described above (including reaching the Plan's Lifetime Maximum), you will be provided with a certificate showing your periods of coverage under the Plan, and any Waiting Periods for coverage. You may be able to use this "creditable coverage certificate" when you acquire new health coverage, to avoid all or part of any Pre-Existing condition restriction that might apply to you under that new coverage. You will receive a creditable coverage certificate when:

- your coverage as an eligible Employee (or as the Dependent of an eligible Employee) terminates; and when
- your coverage under the Plan's coverage continuation provisions terminates (if you elect coverage under those provisions); and when
- you ask us for a certificate, if you ask for the certificate while covered under the Plan or within 24 months after the later of the events listed above.

In order to ask for a certificate, you (or an authorized representative) must make a request to the Employer/Plan Sponsor either in writing or by telephone. For this purpose, you should use the Employer/Plan Sponsor's contact information as shown in the section titled, *General Information*.

ARTICLE VIII PRE-EXISTING CONDITION RESTRICTION

The Plan limits Benefits for otherwise covered treatment of a Covered Person's Pre-Existing Conditions. The Plan will not pay otherwise Covered Expenses for treatment of a Covered Person's Pre-Existing Condition until the end of the 12-month period (18-month period, in the case of a Late Enrollee) beginning on the Covered Person's enrollment date.

The 12-month (or 18-month) period described above may be reduced by your periods of "creditable coverage" under your prior health insurance policies or prior health plans (although a period of prior creditable coverage will be disregarded if you have a 63-day or longer break in creditable coverage after that period). We will assist you, if necessary, in determining the amount of your prior creditable coverage, and in obtaining information from your prior health insurer or health plan concerning your creditable coverage under that insurance policy or plan. Then, we will tell you how much of the 12-month (or 18-month) period remains to be satisfied in your case, after taking into account your prior creditable coverage. We will make this determination in accordance with the rules and regulations under the Health Insurance Portability and Accountability Act of 1996, as amended. You can appeal our determination in accordance with the claim appeal procedures described later in this booklet.

For purposes of this rule, the term "enrollment date" has the same meaning as described in the definition of Pre-Existing Condition.

Notwithstanding anything above to the contrary, in the case of an eligible Dependent who is a Child, such Child will be deemed to have at least 18 months of creditable coverage, regardless of the Child's actual period of creditable coverage, provided the Child was enrolled under creditable coverage within 30 days after birth, adoption or placement for adoption, and did not thereafter experience a 63-day or longer break in creditable coverage.

This Pre-Existing Condition limitation shall not apply to any Covered Person who is a Dependent Child and who is adopted by or placed for adoption with an Employee or who is covered due to a QMCSO.

This Pre-Existing Condition limitation shall not apply to any Dependent that has enrolled as the result of a special enrollment event under the Children's Health Insurance Program Reauthorization Act of 2009.

The Pre-Existing Condition Restriction shall not apply to any Covered Expense obtained through the Plan's contracted pharmacy benefit manager.

The period between an Employee's COBRA qualifying event and the first day of a Special Trade Act COBRA election period will not be treated as a break in creditable coverage.

The period between an Employee's COBRA qualifying event and the first day of COBRA coverage as a result of The American Recovery Act of 2009 will not be treated as a break in creditable coverage.

ARTICLE XIV
HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996
PRIVACY & SECURITY REQUIREMENTS

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information (“PHI”) pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. “Protected Health Information” means health information (including oral information) that:

- is created or received by health care providers, health plans or health care clearinghouses;
- relates to an individual’s past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
- identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

HIPAA also imposes special requirements upon the Plan and the Employer with respect to *electronic* PHI (“ePHI”). Electronic PHI is PHI, as defined above, that is transmitted by or maintained in “electronic media”, as that term is defined in federal regulations, specifically 45 C.F.R. § 160.103.

EFFECTIVE DATE

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy and Security regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan.

DISCLOSURES OF PHI/ePHI BY THE PLAN TO THE EMPLOYER

The Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI/ePHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer’s obligations described below (in the sections titled, *Employer Obligations with Respect to PHI Obtained from the Plan* and *Additional Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, accounting, auditing and monitoring. However, only the minimum amount of PHI/ePHI necessary to accomplish a particular Plan administrative function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI/ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information, including electronic summary health information, to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. “Summary health information” is health information that summarizes claims history, expenses or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information, including electronic enrollment and disenrollment information, to the Employer without the consent or authorization of the Covered Person.

EMPLOYER OBLIGATIONS WITH RESPECT TO PHI OBTAINED FROM THE PLAN

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
- ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
- not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
- report to the Plan any improper uses or disclosures of the PHI;
- provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
- make available to appropriate federal authorities the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan; and
- return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

ADDITIONAL EMPLOYER OBLIGATIONS WITH RESPECT TO ePHI OBTAINED FROM THE PLAN

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan;
- ensure that the adequate separation (as required by 45 C.F.R. § 164.504(f)(2)(iii)), between the ePHI and persons who have no legitimate need to access such ePHI, is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware.

USE AND DISCLOSURE OF PHI BY THE EMPLOYER; DISPUTE RESOLUTION

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the Employee Benefits Department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in the section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Employee Benefits Department for more information regarding the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the Employee Benefits Department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.