Medical Expense Reimbursement Plan

Summary Plan Description

As adopted by

Kingman County Retirement Home Assn dba The Wheatlands Health Care Center

Effective December 1, 2023

Third Party Administrative Services by
Freedom Claims Management, Inc.
P.O. Box 1365
Great Bend, KS 67530
(866) 792-9151

Medical Expense Reimbursement Plan

General Information

1. Introduction

Kingman County Retirement Home Assn dba The Wheatlands Health Care Center ("Employer") has established a plan for payment of certain medical expenses for the benefit of its eligible employees. It is named and known as a "Medical Expense Reimbursement Plan" and will be referred to in this document as the "MERP Plan."

The MERP Plan is provided in conjunction with, and is intended to be integrated with, your Employer's major medical plan, which is referred to in this SPD as the Group Medical Plan. The MERP Plan is designed to reimburse eligible employees (those that are participating in the Employer's Group Medical Plan) for a portion of their and their Spouse's and Dependents' health claims that count toward the deductible under the Employer's Group Medical Plan while they are employed with the Employer and the MERP Plan remains in effect.

Please note that it is not necessary that you have actually paid an amount due for an Eligible Medical Care Expense--only that you have incurred the expense, that you have submitted it to the Group Medical Plan's insurance carrier or third party administrator, as applicable, that it has been processed and reported by them via the Explanation of Benefits ("EOB"), and that it is not being paid for or reimbursed from any other source.

2. Purpose of this Summary Plan Description

This Summary Plan Description describes the basic features of the MERP Plan, how it operates, and how you can get the maximum advantage from it. It also serves as the plan document for the MERP Plan.

3. Interpretation / Coordination with Other Documents

A. In the event that there is a discrepancy or inconsistency between this Summary Plan Description and any other information that might be provided about this MERP Plan, including, but not limited to, any other information that might be provided during open enrollment, the provisions of this Summary Plan Description will prevail.

B. If there is a conflict between the provisions of this Summary Plan Description and the provisions of the Employer's Group Medical Plan with which this MERP Plan is integrated, the provisions of the Employer's Group Medical Plan will prevail.

C. The MERP Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the MERP Plan are intended to be eligible for exclusion from your gross income under Code § 105(b).

D. The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the MERP Plan, and to render decisions on the administration of the MERP Plan, including any factual and legal determinations as to whether an individual is eligible to be enrolled in and/or receive any benefit under the terms of the MERP Plan. The Plan Administrator has the authority to take such corrective action as it might consider to be appropriate in the event that an error in administering the MERP Plan has taken place.

4. Not a Contract of Employment

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

5. The Source of MERP Plan Contributions

Your Employer supplies the funds for the MERP Plan based on actual claims as incurred.

6. Effective Date of the Plan
December 1, 2023

7. How Long Will the MERP Plan Remain in Effect?
Although the Employer expects to maintain the MERP Plan indefinitely, it has the right to modify or terminate the MERP Plan at any time. Such action shall not prevent any employee from claiming reimbursement for expenses that were incurred before such amendment or termination.

8. Plan Year
Your Group Medical Plan's carrier's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year for the MERP Plan is the same as the Plan Year for the Group Medical Plan. The first Plan Year begins on December 1, 2023, and ends on November 30, 2024. In subsequent years, it begins on December 1st and ends on November 30th. Benefits under the Group Medical Plan and the MERP Plan are paid on a Plan Year basis beginning December 1st and ending on November 30th.

9. Plan Sponsor/Employer's Name and Address
Kingman County Retirement Home Assn dba The Wheatlands Health Care Center
750 W Washington
Kingman, KS 67068

10. Plan Sponsor's Tax Identification Number
Kingman County Retirement Home Assn dba The Wheatlands Health Care Center – 48-1022366

11. Plan Administrator's Name, Address, and Phone Number
Kingman County Retirement Home Assn dba The Wheatlands Health Care Center
750 W Washington
Kingman, KS 67068
(620) 532-5801

12. Third Party Administrator
Your Employer has contracted with Freedom Claims Management, Inc. ("FCMI"), which is headquartered in Great Bend Kansas, to process the claims under the MERP Plan on its behalf.

13. Plan Number
The Plan Number for this MERP Plan is the same as the Plan Number for the Group Medical Plan.

14. Plan's Agent for Service of Legal Process
Kingman County Retirement Home Assn dba The Wheatlands Health Care Center
750 W Washington
Kingman, KS 67068

15. Who is Eligible for Medical Reimbursements under the MERP Plan?
Any eligible employee of the Employer who is eligible to participate in the Employer's Group Medical Plan is eligible to participate in the MERP Plan. Participation in the MERP Plan is automatic upon your participation in the Group Medical Plan. It is not, however, possible to participate in the MERP Plan unless you are also participating in the Group Medical Plan. The Employer also offers a Group Medical Plan high deductible health plan ("HDHP"). If you enroll in the Group Medical Plan HDHP only, you are not eligible to participate in the MERP Plan.

16. Does the MERP Plan Provide Benefits for my Family?
The MERP Plan provides reimbursement for eligible Medical Care Expenses incurred by you, your Spouse, and any of your Dependents if that person was also covered by the Group Medical Plan when the Medical Care

Expenses were incurred. In no event, however, will the Plan reimburse you for more than the difference between what you were actually charged and the amount that was actually paid by the Group Medical Plan.

17. When Am I Eligible for Coverage under the MERP Plan?

You are eligible for coverage under the MERP Plan on the same day you become eligible for coverage under the Employer's Group Medical Plan. To receive coverage under the MERP Plan, you must be enrolled in the Employer's Group Medical Plan.

18. When Must the Medical Care Expenses Be Incurred for Which I May Be Reimbursed?

An eligible Medical Care Expense must have been incurred during the Plan Year. You may not be reimbursed for (a) any expenses arising before the MERP Plan became effective, (b) before you became covered under the MERP Plan, (c) any expenses incurred after the end of the Plan Year, or (d) any expenses incurred after the last day of the month in which your employment was terminated (unless COBRA continuation coverage has been elected).

19. What is an Eligible Medical Care Expense?

An eligible Medical Care Expense is an expense incurred by the Employee, the Employee's Spouse, or the Employee's Dependents, for medical care as defined in Code § 213 (for example, hospital and doctor bills) not otherwise reimbursed by the underlying medical policy or any other insurance, and not including health insurance premiums for individual policies or for any other group health plan. For purposes of this MERP Plan, an expense is "incurred" when the covered individual is furnished the medical care or services giving rise to the claimed expense.

20. How Will My Medical Care Expenses Be Paid under the MERP Plan?

The following is the general process for submitting a claim:

- **A.** A health-care provider will file the claim to the primary carrier.
- **B.** Once the provider receives processing from primary carrier, the provider will file the claim to the MERP Plan. This can be done either by submitting a paper claim with the EOB, or filing it electronically to EDI #67136 with the primary processing information.
- **C.** Once a clean claim is received, it is processed according to the MERP Plan.
- **D.** The MERP Plan will then pay the provider, unless MERP Plan benefits are not available or you show proof of prior payment of the claim.
- **E.** A clean claim will be processed within 30 days unless additional information is requested.

21. Coordination of Benefits

The MERP Plan will reimburse you only in the event and to the extent that the Medical Care Expenses are not covered by any insurance policy, policies, or benefits, whether owned by you or the Employer, provided under any other accident or health insurance plan, provided by federal or state governments or agencies, or provided by any other source. In the event that such a policy or benefits are in effect, the MERP Plan shall be relieved of any responsibility for Medical Care Expenses covered by the policy, policies, or benefits.

22. Termination of Coverage under the MERP Plan

Participation in the MERP Plan will terminate on the earliest of:

- **A.** The last day of the month on which you cease to be an employee;
- **B.** The last day of the month on which you cease to meet the eligibility requirements of the MERP Plan (e.g., you lose coverage under the Group Medical Plan by failing to pay any applicable premium);
- **C.** The last day on which you may claim benefits under the Group Medical Plan with which this MERP Plan is integrated (in most cases, this will be the last day of the month, but it could be earlier depending on the terms of the Group Medical Plan); or
- **D.** The date the MERP Plan is amended to exclude you from participation or is terminated.

Notwithstanding anything in this Question 22 to the contrary, an individual who would normally be required to terminate participation may continue to participate in this MERP Plan if and to the extent such individual elects continuation of benefits under the rules in Section 26.

23. Does my Coverage under this MERP Plan End When my Employment Terminates?

Yes. Your participation will cease at the end of the month in which your employment with the Employer terminates. However, you and your family will have the opportunity to continue to be covered under the MERP Plan under the terms of the Continuation Coverage provisions described below.

24. Circumstances that may Result in Loss or Denial of Benefits under the MERP Plan

Circumstances that may result in a loss or denial or benefits under the MERP Plan may occur are included, but not limited to, the following:

- **A.** The person was not covered under the MERP Plan when the expense was incurred.
- **B.** The expense is not a Medical Care Expense.
- **C.** The expense was covered by, and paid for by, the Group Medical Plan.
- **D.** The maximum benefit limits for the MERP Plan have been reached.
- **E.** The expense was incurred outside of the Plan Year.
- **F.** Coordination of Benefits.

25. What Happens if my Claim for Benefits is Denied?

- **A.** All claims are adjudicated (reviewed for approval under the provisions of the MERP Plan) by FCMI.
- **B.** You will be notified in writing by FCMI via EOB within 30 days of the date you or your health-care provider submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. If your claim is denied due to the failure to submit certain information that is necessary to process a claim, you will be notified of such failure within 30 days of receipt of the claim, along with the specific information necessary to complete the claim. You will then have 45 days to provide the requested information to FCMI. FCMI will decide the claim within the number of days remaining in the original 30-day period. If the requested information is not timely received, FCMI will deny the claim in writing.
- **C.** If a claim is denied under the MERP Plan but approved under the Insured Health Plan, you will further be advised in writing of your right to request an administrative review of the denial of such claim, and you may request a review any time within the 180-day period after you have received notice that such claim was denied. You will be informed of the specific reason(s) for the denial, the specific MERP Plan provisions upon which the denial is based, the MERP Plan's claim review procedures and their time limits as well as a statement of your right to bring a civil action under ERISA § 502(a) following an adverse benefit determination on review, and, if an internal rule, guideline or protocol was relied upon in making the adverse determination, the notification will either state the internal rule, guideline, or protocol that was used or include a statement what such criterion was used and that a copy of the rule, guideline, or protocol will be provided free of charge upon request.
- **D.** You or your authorized representative will have the opportunity to review any important documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. You will be notified of the decision made upon review. If the claim is denied again, you will be told the specific reason for the denial and given references to specific MERP Plan provisions upon which the determination was based as well as your right to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- **E.** Before initiating legal action concerning a claim against this MERP Plan, the Employer, FCMI and/or the Plan Administrator, you must first exhaust the administrative remedies set forth in the MERP Plan's claims procedures. Failure to exhaust the administrative remedies provided in MERP Plan's claims procedures shall be a bar to any civil action concerning a claim for benefits under the MERP Plan.

26. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse's and Dependents' rights, to continue to be covered under the MERP Plan (and Insured Health Plan) if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of a "Qualifying Event." You must also continue coverage under the Insured Health Plan in order to continue benefits hereunder. A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours.
- Your death.
- Divorce or legal separation from your Spouse.
- Your becoming eligible to receive Medicare benefits.
- Your dependent ceasing to be a Dependent.

In the event that you elect continuation coverage under the Group Medical Plan, you will also automatically receive continuation coverage under this MERP Plan because this MERP Plan is integrated with the Group Medical Plan. The benefits that you receive in conjunction with the continuation coverage under this Plan will be the same as what you would have received had coverage been in place as a result of your active employment.

Other Considerations

27. ERISA Statement of Participant Rights

As a Participant in the MERP Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA").

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the MERP Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the MERP Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 the 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 benefit from the plan, or from exercising your rights under ERISA. If your claim for a benefit under the MERP Plan provisions is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the MERP Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the MERP Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that the plan's fiduciaries misuse the MERP 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. If you have any questions about the MERP Plan, you should contact the Plan Administrator. If you have any questions about this Part of the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory

or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., 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.

28. Family and Medical Leave *(applicable to groups with 50+ employees)*

As an employee of Employer, you may be entitled under the federal Family and Medical Leave Act (FMLA) to certain rights. If you take FMLA leave, the Employer will continue to maintain your coverage under the MERP Plan to the extent required by the FMLA on the same terms and conditions as if you were still an active eligible employee. Under special rules that apply if you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA even if you were not covered under the plan during the leave. Contact the Employer for more information about these special rules and FMLA rights and benefits while on FMLA leave.

Uniformed Services Employment and Reemployment Rights Act

Pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if you are absent from employment as a result of military service, you have the right to elect continuation coverage for a period of up to 24 months. Your right to continue coverage is subject to the following:

A. You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than 31 days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than 30 days, you must pay the entire cost of coverage plus an additional 2%.

B. Following the completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your Employer's group health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

29. Non-FMLA and Non-USERRA Leaves of Absence

For non-FMLA and non-USERRA leaves of absence, this MERP Plan follows the requirements for the same set forth in the Group Medical Plan.

30. Qualified Medical Child Support Orders

A "qualified medical child support order" is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law, which either creates or extends the rights of an "alternate recipient" to participate in a group health plan, including the MERP Plan, or enforces certain laws relating to medical child support. An "alternate recipient" is any child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant's group health plan. A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator when it receives a medical child support order that applies to you, and the MERP Plan's procedures for determining whether the medical child support order is qualified. You may obtain from the Plan Administrator, without charge, a copy of the MERP Plan's procedures governing the determination of whether an order is a "qualified medical child support order."

31. Definition of "Dependent"

A "Dependent" for purposes of the MERP Plan is an individual who is a "Dependent" of the employee under the terms and conditions of the Group Medical Plan and who is also enrolled in both the Group Medical Plan and the MERP Plan.

32. Your HIPAA Privacy Rights--Use and Disclosure of Protected Health Information (PHI)

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits

the MERP Plan from using or disclosing certain health information about you that is created or received by the MERP Plan without your written authorization. For additional information about your privacy rights, please refer to the MERP Plan's Privacy Notice or contact the MERP Plan's Privacy Official. Protected Health Information generally includes all information, whether written or oral, in connection with the MERP Plan that (1) is created or received by the MERP Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you. If you wish to authorize the MERP Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the MERP Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures

The MERP Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the MERP Plan's Privacy Notice or contact the MERP Plan's Privacy Official.

Disclosures to the Employer

After the Employer has certified to the MERP Plan that it is in compliance with the Privacy Rule, the MERP Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform MERP Plan administration functions. The MERP Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the MERP Plan may not disclose PHI to the Employer for purposes of any employment-related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- Not use or further disclose PHI other than as permitted or required by the official MERP Plan document or as required by law;
- Ensure that any agents to whom the Employer provides PHI (or certain electronic PHI) received from the MERP Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- Report to the MERP Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the MERP Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the MERP Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI (or certain electronic PHI) to the following Employer employees and may only do so to the extent that the Employer employees perform plan administration functions:

- The HIPAA Privacy Official;
- Employees in the Employer's Human Resources Department;
- Employees in the Employer's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

If an employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

The MERP Plan’s privacy provisions are specified in more detail in the attached HIPAA Medical Privacy Appendix. In the event of a conflict between the summary provided above and the provisions set forth in the attached HIPAA Medical Privacy Appendix, the provisions of the attached Medical Privacy Appendix will control.

HIPAA MEDICAL PRIVACY APPENDIX

PART I
PREAMBLE

Section A1.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section A1.02 Application of HIPAA Medical Privacy Appendix. The Kingman County Retirement Home Assn dba The Wheatlands Health Care Center is a "hybrid entity." As such, the Plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the Plan.

This Article shall *only* apply to the Kingman County Retirement Home Assn dba The Wheatlands Health Care Center medical benefits (hereafter referred to as the "Group Health Plan").

All other benefits provided by the Employer through the Kingman County Retirement Home Assn dba The Wheatlands Health Care Center are either (a) not "group health plans" as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information (PHI) other than "summary health information" as defined in 45 C.F.R. Section 164.504(a) or enrollment and disenrollment information.

The Article shall supersede the provisions of the Group Health Plan to the extent those provisions are inconsistent with the provisions of this Article.

PART II
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section A1.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section A1.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

(a) *"Breach"* means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use, or disclosure are excluded from the definition of a "breach:"

(i) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;

(ii) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and

(iii) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(b) *"De-identified Health Information"* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

(c) *"Electronic Media"* means:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, 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 paper, facsimile, and 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.

(d) *"Electronic Protected Health Information" ("e-PHI")* is PHI that is transmitted or maintained in electronic media.

(e) *"Individually Identifiable Health Information"* means information for which each of the following conditions is met:

(i) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;

(ii) The information relates to the past, present, or future physical or mental health 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; and

(iii) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(f) *"Plan Administration Functions"* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.

(g) *"Protected Health Information (PHI)"* means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(h) *"Security Incident"* (as defined in 45 C.F.R. 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(i) *"Security Rule"* shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.

(j) *"Summary Health Information"* means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.

(k) *"Unsecured PHI"* means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section A1.05 Enrollment and Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section A1.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

(b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;

(c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;

(d) Conducting cost management and planning-related analysis, including the forecasting of expected health care costs based on current utilization of benefits;

(e) Detecting fraud or abuse;

(f) Determining whether charges for services are appropriate or justified;

(g) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance;

(h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

(i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;

(j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

(k) Reporting corporate finances with respect to current and projected health care costs;

(l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services ("HHS") in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section A1.06 is subject to the provisions of Section A1.07.

Section A1.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section A1.06, the Employer agrees and certifies to the Group Health Plan as required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations to do the following:

(a) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;

(b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;

(c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;

(d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and HHS may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

(e) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

(f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;

(g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;

(h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;

(j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;

(l) Provide a certification to the Group Health Plan as required by Section A1.08; and

(m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(ii) Ensure that any agent (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and

(iii) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section A1.08 Certification by the Sponsor. The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section A1.07.

By adoption of this Plan document and delivery of a copy of the Plan document to the privacy officer, the Plan Sponsor certifies that (a) the provisions of 45 C.F.R. § 164.504(f)(2)(ii) have been incorporated into the Plan document; and (b) the Plan Sponsor has agreed to the conditions of disclosure set forth in Section A1.07.

PART III
ADMINISTRATIVE SAFEGUARDS

Section A1.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the "authorized employees" have access to e-PHI. Further, this Part III does not apply

to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section A1.10 Authorized Employees. The following Employees ("Authorized Employees") are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Participants:

Privacy Officer
Human Resources

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel's support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section A1.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section A1.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

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