COMMISSIONERS COURT COMMUNICATION

AGENDA DATE: 7/23/2012

CONSENT OR REGULAR: Regular

CONTRACT REFERENCE NO (IF APPLICABLE): 2012-0320

SUBJECT: Approve the Summary Plan Description for the County's Medical Flexible Spending Account, Dependant Care Flexible Spending Account, and Premium Only Plan. (125 Cafeteria Plan) The Summary Plan Description was approved by the Risk Pool Board during their meeting on June 25, 2012 and reviewed by the County Attorney's Office.

BACKGROUND/DISCUSSION OF TOPIC:

The County of El Paso has sponsored a Medical Flexible Spending Account, Dependant Care Flexible Spending Account, and Premium Only plan. The purpose of the plan, which is commonly referred to as a "cafeteria plan", is to allow eligible employees to pay qualified medical and dependent care expenses using pre-tax dollars. This Summary Plan Description establishes up to date procedures and replaces the plan established in 2001 and revised in 2004.

FISCAL IMPACT:

The County is self-insured for Medical, Prescription Drug, and Dental Benefits through the Risk Pool Fund. The proposed Summary Plan Description memorializes current procedures and should not have a significant cost impact to the fund.

PRIOR COMMISSIONERS COURT ACTION:

Oct 8, 2001 - Commissioners Court approved the 125 Cafeteria Plan.
Nov 22, 2004 - Commissioners Court approved the Revised 125 Cafeteria Plan.

RECOMMENDATION:

Staff recommends for the Commissioners Court to approve the Summary Plan Description for the County's Medical Flexible Spending Account, Dependant Care Flexible Spending Account, and Premium Only plan.

COUNTY ATTORNEY APPROVAL:

The Summary Plan Description has been reviewed and approved by the County Attorney's Office. (2012-0320)

SUBMITTED BY:	Sam Trujillo, Risk Manager Human Resources Department		

COUNTY OF EL PASO

MEDICAL FLEXIBLE SPENDING ACCOUNT, DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT AND PREMIUM ONLY PLAN

Plan Documents and Summary Plan Descriptions
Effective: July 23, 2012

TABLE OF CONTENTS FOR THE MEDICAL FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT, AND PREMIUM ONLY PLAN

PURPOSE OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT

What is the purpose of the "*Plan*"?

County of El Paso (the "*Plan Sp*onsor") has adopted this Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan (the "*Plan*") as set forth herein and as amended from time to time for the exclusive benefit of eligible *employees*. The purpose of this *Plan* is to allow eligible *employees* to pay eligible *qualified medical flexible spending expense, qualified dependent care flexible spending expenses*, and their share of premiums under the *benefit plan ("benefit costs*") using pre-tax dollars.

The intention of the *Plan Sponsor* is that the *Plan* qualifies as a "cafeteria plan" within the meaning of *Code § 125* and the *Plan* shall be construed in a manner consistent with that Section. The tax implications of this *Plan*, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the *Plan Sponsor* does not represent or warrant to any *participant* that any particular tax consequence will result from participation in this *Plan*. By participating in this *Plan*, each *participant* understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the *Plan*, the recipient of the benefit will be responsible for those amounts, without contribution from the *Plan Sponsor.*

This *Plan* is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under the *Code §§* 105 and 125.

Effective date

This *summary plan description* is effective as of **July 23, 2012**, and each amendment is effective as of the date set forth therein (the "effective date").

Adoption of the *summary plan description*

The *Plan Sponsor*, as the settler of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* amends and replaces any prior statement of the benefits contained in the Plan or any predecessor to the *Plan*.

IN WITNESS WHEREOF, the *Plan Sponsor* has caused this Plan Document to be executed.

GENERAL PLAN INFORMATION

Name of *Plan*:	County of El Paso Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan
Plan Sponsor:	County of El Paso; 800 E. Overland, Suite 223, El Paso, TX 79901
***Plan Administrator*:** (Named Fiduciary)	County of El Paso; 800 E. Overland, Suite 223, El Paso, TX 79901
***Plan Sponsor* ID No. (EIN):**	**74-6000762**
***Plan* year:**	January 1—December 31; Subsequent plan years January 1—December 31
***Plan* Type:**	Medical Flexible Spending Account, Dependent Care Flexible Spending Account
Third party administrator:	HealthSCOPE Benefits, Inc., 27 Corporate Hill Drive, Little Rock, AR 72205
Participating employer(s):	County of El Paso
Agent for Service of Process:	County of El Paso; 800 E. Overland, Suite 223, El Paso, TX 79901

DEFINITIONS

In this section, you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this *summary plan description* for that information.**

"Active employment" means performance by the *employee* of all the regular duties of his or her occupation at an established business location of the *participating employer*, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An *employee* will be deemed *active employee* if the *employee* is absent from work due to a health factor.

"Alternate recipient" means any child of a *participant* who is recognized under a *medical child support* order as having a right to benefits under this *Plan* as a *participant's dependent*. For purposes of the benefits provided under this *Plan,* an *alternate recipient* shall be treated as a *dependent.*

"Benefit cost" means the cost of premiums for medical, dental, vision, prescription drug, and over-the-counter drug coverage for a *participant*, his or her *spouse*, and *dependent* children under the *benefit plan* which a *participant* is required, as a condition of coverage, to pay.

"Benefit plan" means the medical, dental, vision, prescription drug, and over-the-counter drug benefits provided under a group health plan established and maintained by the *Plan Sponsor*, or any successor thereto.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"***Code"*** means the Internal Revenue Code of 1986, as amended.

"Cosmetic surgery" means any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

"*Dependent*" means any of the following:

- Individuals who meet the definition of "*dependent*" under Internal Revenue Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof;
- Any child, adopted child, or eligible foster child (as each is defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27; or
- Any child of the *participant* to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and for purposes of the DCAP Component, a *qualifying individual*.

Notwithstanding the foregoing, the *Plan* will provide benefits in accordance with the applicable requirements of any Medical Child Support Order "*MCSO"*, even if the child does not meet the definition of *dependent*.

"***Dependent care center"*** means any facility which:

- Complies with all applicable laws and regulations of the state and unit of local government in which it is located;

- Provides care for more than six individuals (other than individuals who reside at the center); and

- Receives a fee, payment or grant for providing services for any of such individuals (regardless of whether such facilities operated for profit).

"Earned income" means the sum of the amounts set forth in the first section below, but shall exclude the amounts set forth in the second section below:

Earned income include the following:

- Wages, salaries, tips and other employee compensation, but only if such amounts are includable as gross income for the taxable year; and
- The amount of an *employee's* net earnings from self employment for the taxable year (within the meaning of *Code* § 1402 (a)). Such net warnings shall be determined with regard to the deductions allowed to the *employee* under *Code* § 164 (f).

Excluded:

- Amounts received under this *Plan* or any other dependent care assistance plan under *Code* § 129;
- Amounts received as a pension or annuity (within the meaning of *Code* § 32 (c)(2);
- Amounts to which *Code* § 871(a) applies;
- Amounts attributed to an individual pursuant to community property laws (within the meaning of *Code* § 32 (c)(2);
- Amounts attributable to wages or salary which were reduced pursuant to a written *salary reduction agreement;* and
- Amounts received for services provided by the *participant* while the *participant* is incarcerated in a penal institution.

"Employee" shall mean (1) a person who is a regular full-time Employee of the Participating Employer; or (2) county and district officers and as otherwise permitted by the Plan Administrator pursuant to Section 157.01(a) of the Texas Local Government Code, as amended.

"FMLA" means the Family Medical Leave Act of 1993, as amended.

"*FMLA leave"* means a leave of absence which the participating employer is required to extend an *employe*e under the provisions of *FMLA*.

"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"Health care expense" means an expense *incurred* for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of function of the body. A *health care expense* is not one that is merely beneficial to the general health of an individual.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Incurred" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are *incurred* for the various steps or phases as the services related to each step are rendered and not when services related to the initial step or phase are rendered. More specifically, *qualified medical flexible spending expenses* for the entire procedure or course of treatment are not incurred upon commencement of the first state of the procedure or course of treatment.

"Medical child support order" **or** ***"MCSO"*** means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a participant's child or directs a participant to provide coverage under a health *benefit plan* pursuant to a state domestic relations law (including community property law); or

- Enforces a law related to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.

"National medical support notice" **or** ***"NMSN"*** means a notice that contains the following information:

- The name of an issuing state agency;

- The name and mailing address (if any) of an *employee* who is a participant in the *Plan*;

- The name and mailing address of one or more alternate recipients or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipient(s);* and

- The identity of an underlying child support order.

"Open enrollment period" means the month of October each year when eligible *employees* may enroll for participation and make elections under the *Plan* for the following *plan year*.

"Participant" means an eligible employee who is participating in the *Plan*.

"Participating employer(s)" means the County of El Paso.

"Plan" means the County of El Paso, Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan.

"Plan Administrator" means the County of El Paso.

"Plan Sponsor" means the County of El Paso.

"Plan year" means the period from January 1 through December 31.

"Premium only plan" means the vehicle through which a *participant* may elect to pay his or her share of *benefit costs* by reducing his or her salary and using pre-tax dollars.

"Privacy standards" means the final rule implementing HIPAA's Standards for Privacy of Individually Identifiable Health Information, as amended.

"Qualified beneficiary" means:

- An individual who, on the day before a *qualifying ev*ent, is a *spouse* or *dependen*t child receiving health benefits under the *Plan*; or

- In the case of a *qualifying event* resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such *qualifying event*, is a *participant*.

A newborn child of, an adopted child or, or a child placed for adoption with, a *qualified beneficiary* (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the *qualified benefi*ciary; however, such child shall not become a *qualified beneficiary*.

A newborn child or child placed for adoption with a *qualified beneficiary* (as defined in the second bullet above) shall become a qualified beneficiary in his or her own right and shall be entitled to benefits as a *qualified beneficiary*.

A *qualified beneficiary* must notify the *Plan Administrator* within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

"Qualified dependent care flexible spending account" means the account established by the *Plan Administrator* on behalf of a *participant* who elected to have amounts withheld from his or her salary in order to pay *qualified dependent care flexible spending expenses*.

"Qualified dependent care flexible spending expenses" means employment-related dependent care expenses which are eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e)(1) and 21(b). Such expenses include amounts paid for household services and for the care of *qualifying individuals* enabling the *participant* to be gainfully employed.

"Qualified medical child support order"* or *"QMCSO" means a *medical child support order* that creates or recognizes the existence of an *alternate recipient's right* to, or assigns to an *alternate recipient* the right to, receive health benefits for which a *participant* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *qualified medical child support order*, it must clearly specify the following:

- The name and last known mailing address (if any) of a *participant* and the name and mailing address of each such *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan.*

In addition, a *national medical support* notice shall be deemed a *qualified medical child support order* if it:

- Contains the information set forth above in the definition of *national medical support notice*;
- Identified either the specific type of coverage or all available group health coverage. If the *participating employer* received a *national medical support notice* that does not designate either specific types of coverage or all available coverage, the participating employer and the *Plan Administrator* will assume that all are designated;
- Informs the *Plan Administrator* that, if a group health plan has multiple options and a *participant* is not enrolled, the issuing agency will select the Core Plan after the *national medical support notice* is qualified; and
- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the Plan or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to a *participant* and eligible *dependents*, except to the extent necessary to meet the requirements of a state law relating to *medical child support order*, as described in Social Security Act § 1098 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

"Qualified medical flexible spending account" means the account established by the *Plan Administrator* on behalf of the *participant* through which the participant may elect to reduce his or her salary in order to pay *qualified medical flexible spending expenses.*

"*Qualified medical flexible spending expenses"* means a *health care expense* which is excludable as income according to Code § 105(b). *Qualified medical flexible spending expenses* are not otherwise reimbursable under the *benefit plan* or other plan or by an other entity and may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

"Qualified reservist distribution" means, any distribution to an individual of all or a portion of the balance in the participant's *qualified medical flexible spending account* if:

- Such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code) ordered or called to active duty for a period in excess of 180 days or for an indefinite period; and

- Such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangements for the *plan year* which includes the date of such order or call.

"Qualifying individual" means:
- A *dependent* of a *participant* (as defined in Code § 152(a)(1) who is under the age of 13;

- A *dependent* of a *participant*, regardless of age, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the *participant* for more than one- half of the tax year; or

- The *spouse* of a *participant* who is physically or mentally incapable of caring for himself or herself who has the same principal place of abode as the *participant* for more than one-half of the tax year.

"Qualifying event" means any of the following with respect to participation in the *Plan*:
- The termination of coverage due to the death of a *participant*;

- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a *participant*;
- The divorce or legal separation of a *participant* from his or her *spouse*;
- Reduction in covered *participant's* hours of employment;
- Birth of a child
- Death of the covered *participant*;
- A *participant's* entitlement to Medicare coverage; or
- A *dependent* child ceasing to be a dependent child.

"Salary reduction agreement" (Section 125 Cafeteria Plan) means a written agreement by a *participant* to reduce his or her salary or wage in order to fund a *qualified medical flexible spending account*, a *qualified dependent care flexible spending account*, or to pay *benefit costs*. This written agreement can be in the form of a paper-based election or a web-based election made by the *participant* as provided for by the employer.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

You are eligible to participate in the *Plan* if you are a County Of El Paso employee. However, you may elect to make contributions to the *Premium Only Plan* only if you participate in the *benefit plan*.

When will my participation begin?

If you are a new *employee*, your entry date for the *Plan* is contingent upon completion of the eligibility requirements outlined above. If you are a new *employee* who is eligible to participate, your entry date is the first day that you become eligible, provided that you have completed a *salary reduction agreement*. You must complete a proper *salary reduction agreement* within 31 days from your original eligibility date in order to participate in the *Plan* for the *plan year*.

After year one, if you are enrolling during an open enrollment period, our entry date will be January 1 following the *open enrollment period*, provide that you have completed a *salary reduction agreement*.

By completing the ***Salary Reduction Agreement*** you will be enrolling in this *Plan*. If you participate in the *benefit plan*, you may elect to reduce your salary so that your share of the premiums for the *benefit plan* are paid using pre-tax dollars. Additionally, you may elect to contribute to a *qualified medical flexible spending account* or a *qualified dependent care flexible spending account*. Eligible *employees* who do not participate in this *Plan* may not pay any required conditions to the *benefit plan* with pre-tax dollars, nor may they pay qualified *medical flexible spending expenses* or *qualified dependent care flexible spending expenses* using pre-tax dollars.

Unless you experience a change in circumstances, as described below, your *salary reduction agreement* will continue in force for that *plan year,* and you will be required to complete a new *salary reduction agreement* for each subsequent *plan year* for which you decide to participate in the *Plan*. However, once you elect to contribute to a *premium only plan*, that election will continue to remain in effect from *plan year* to *plan year*, unless you affirmatively elect to cease your participation by so indicated on a new *salary reduction agreement*. If you decide to discontinue your participation in the *premium only plan* during the annual election period, you must affirmatively indicate your intention to do so by completing a new *salary reduction agreement*.

If you do not submit the *salary reduction agreement* to the *Plan Administrator* within 31 days of becoming eligible, or during the *open enrollment period*, it will be assumed that you have decided not to participate in the *Plan*, and you will not have the opportunity to enroll until the next *open enrollment period* or following a change in status event described below.

May I elect not to participate in the *benefit plan*?

You may elect not to participate in the *benefit plan* by completing and filing an appropriate election/declination form with the *Plan Sponsor* within 31 days of your original eligibility period or an *open enrollment period*.

May I make mid-year changes in my *Plan* elections?

Generally, you cannot change your election to participate in the *Plan* or decrease or increase the amount you have elected to contribute to your account(s) once the *plan year* begins. However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. Change in status events include:

- Marriage.
- Divorce, legal separation, or annulment.
- Death of a *spouse* or *dependent*.

- Termination or commencement of employment by you, your *spouse*, or your *dependent.*
- Reduction or increase in hours of employment by you, your spouse, or your *dependent* child (meaning a change from full-time to part-time employment status or vice versa).
- Place of residence change by you, your *spouse*, or your *dependent*, which results in a change in eligibility.
- Your *dependent* satisfies or cease to satisfy the requirements for coverage.
- Commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent*.
- A significant change in the cost of dependent care.
- A change in dependent care providers.
- A dependent care provider's cessation of business.
- A change in worksite of you, your *spouse*, or your *dependent*.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your *spouse*, or your *dependent*.
- If you, your *spouse*, or your *dependent* becomes eligible for *COBRA* continuation coverage under the *benefit plan,* you may elect to change your contributions to the *premium only plan* or the *qualified medical flexible spending account*.
- Any other change in status that the *Plan Administrator*, in its sole discretion, determines will permit a change or revocation of an election during a *plan year* according to regulations and ruling under the Internal Revenue Service.

If you experience such a change in status and wish to change your level of coverage you must submit written notification to the *Plan Administrator* within 31 days of your change in status, as well as a new *salary reduction agreement* reflecting your new contribution elections. The *Plan Administrator* reserves the right to require you to submit proof of any change in status at your expense. The change in coverage becomes effective with the first pay period following the date the written notification is received by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event. Any such change will remain in effect for the remainder of the *plan year*.

Must the election change be consistent with the change in status?
You will be permitted to change an election during the *plan year* and make a new election for the remainder of the *plan year* only if the change you make is consistent with the event. For example, you can only change your election to contribute to the *premium only plan* or the *qualified medical flexible spending account* if:

- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the *benefit plan* or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.

What if there is a change in the cost of coverage during the *plan year*?
If the *benefit costs* increase or decrease during a *plan year*, the *Plan* may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected *participant's* elective contributions for the *premium only plan.*

If the *benefit costs* significantly increase or decrease (as determined by the *Plan's Sponsor*), you may make a corresponding change in your election to participate in the *premium only plan*.

May I continue participation during *FMLA leave*?
If the leave of absence is qualified under the federal Family and Medical Leave Act (FMLA), you have the option to terminate your participation in the Plan or continue your participation in the Plan and make payments as determined by the Plan Administrator in compliance with FMLA requirements. In addition, the Plan Administrator must apply special detailed rules for administering Plan coverage during and after a Participant's unpaid FMLA leave. Contact the Plan Administrator for more information.

May I continue participation while I am absent under *USERRA*?
If you are absent from employment because you are in the *uniformed service*, you may elect to continue your coverage under this *Plan* for up to 24 months. If you elected to continue coverage under *USERRA* before December 10,2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's open enrollment period*, and pay your contribution in accordance with the options outlined above for a *participant* who goes on *FMLA leave*.

When does my participation end?
If you terminate employment with the *participating employer*, your participation in this *Plan* will terminate on the last pay period, unless you elect to continue your participation in accordance with the guidelines provided in the "*COBRA* continuation coverage" section. Any *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses incurred* during the *plan year* prior to the date of termination will be reimbursed by the *Plan* in accordance with the guidelines in the section, "Benefits". Your participation in this *Plan* will also terminate if the *participating employer* decides to terminate this *Plan*, or if you voluntarily decide not to participate under the terms of this *Plan*.

If your participation in this *Plan* terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the *Plan* for the remainder of the *plan year* or continue your participation in accordance with the "*COBRA* continuation of coverage" section. If you do not make payments as required under *COBRA*, it will be assumed that you elected to revoke your participation in this *Plan*.

If your employment terminates, and you return to eligible employment with your *participating employer* more than 30 days following termination of your participation, you may rejoin the *Plan* and make a new election for the remainder of the *plan year*, as long as the termination was not for the purpose of altering the original election.

If you do not complete and file a *salary reduction agreement* during the *annual enrollment period*, your participation will end at the end of the *plan year*.

COBRA continuation of coverage for contributions to a qualified medical flexible spending account

If you are a *participant* in the *Plan*, you, your *spouse* or your *dependents* may be eligible for continued coverage under *COBRA* for contributions made to a *qualified medical flexible spending account*. *COBRA* may give you the right to continue your benefits under a *qualified medical flexible spending account* beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by you. Coverage will end in certain instances, including if you fail to make timely payment of premiums. Generally, a *COBRA* applies to employers with 20 or more employees. You should check with your *participating employer* to see if *COBRA* applies to you.

When am I eligible for *COBRA*?

You may elect *COBRA* coverage if a *qualifying event* occurs and results in a loss of participation in the *Plan*, such as:

- The death of the *participant*.
- The termination of the *participant's* employment (other than by reason of the *participant's* gross misconduct) or reduction in the *participant's* hours of employment.
- The divorce or legal separation of the *participant* from his or her *spouse*.
- A dependent child ceases to be a *dependent* under the terms of the *Plan.*
- The *participant* becomes entitled to *Medicare* benefits.

In the event that the *COBRA* premium for the remainder of the *plan year* exceeds the maximum benefit still available under the *Plan* as of the date of the qualifying event, the *Plan Administrator* has the option to either not offer *COBRA* continuation *qualified medical flexible spending account* coverage, or offer the coverage for the remainder of the *plan year*.

Who may elect *COBRA* coverage?

The following people are known as *qualified beneficiaries* and may elect *COBRA* coverage that will include the benefits to which they were entitled to under *the Plan* on the day before one of the above *qualifying events*:

- The *spouse* or any *dependent* child of the *participant* under *the Plan*.
- The *participant*, if the *qualifying event* is the termination of coverage due to termination of employment or reduction in hours.

If a *dependent* under *the Plan* who is also a *qualified beneficiary* has a newborn child, adopts a child, or a child is placed for adoption with that *dependent*, that child will be entitled to the same *COBRA* coverage period, but will not become a *qualified beneficiary* in his or her own right.

If you have a newborn child, adopt a child, or a child is placed for adoption with you, that child will become a *qualified beneficiary* in his or her right.

Who must be notified when a qualifying event occurs?

For qualifying events such as divorce, legal separation or change in dependent status, you must inform the *Plan Administrator* of the event within 31 days of the event. For qualifying events such as death, termination or reduction in hours, entitlement to Medicare, bankruptcy or failure to return from leave under the *FMLA*, the participating *employee* has 31 days from the date of the *qualifying event*, or the date that you will lose coverage due to the *qualifying event*, in which to notify the *Plan Administrator*. The *Plan Administrator* has the obligation to furnish you, your *spouse* and your *dependents*, if they are eligible to receive benefits under this *Plan*, with separate, written options to continue coverage within 14 days of receiving notice of the *qualifying event*.

You must notify the *Plan Administrator* within 31 days of child's birth, adoption, or placement for adopting in order to add the child to the continuation coverage.

What is the cost of *COBRA* coverage?

If you are eligible for and choose to continue coverage, you will be required to pay 102% of your normal contribution, and 102% of the *employer contribution*. When continuation of coverage for a disabled person is extended form 18 to 29 months the disabled person may be charged 15% of the cost of coverage after the initial 18-month period expires. This contribution will be on an after-tax basis.

How long may coverage be continued?

If you have experienced a *qualifying event* and have a positive balance in your *qualified medical flexible spending account* at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in this *Plan* under *COBRA*. Your *COBRA* coverage period ends on the last day of the *plan year* in which the *qualifying event* occurs.

What is the effect of the Trade Act?

Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits that you may receive under *COBRA*. First, if you lose your job due to international trade agreements, you may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Also, if you lose your job due to international trade agreements, you may be allowed an additional 60-day period to elect *COBRA* continuation coverage. If you elect continuation during this second election period, the coverage period will run form the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applied to you.

Qualified medical flexible spending expenses

If you elect to contribute to a *medical flexible spending account*, the *Plan* will reimburse you for *qualified medical flexible spending expenses* which are *incurred* by you, your *spouse*, or your *dependent* during the *plan year*.

Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount you elected under your *salary reduction agreement* for the *plan year* to contribute to your *qualified medical flexible spending account*. It is important to keep in mind that you cannot use amounts contributed to a *qualified medical dependent care flexible spending account* to pay *qualified medical flexible spending expenses.*

What are *qualified medical flexible spending expenses?*

Qualified medical expenses are *health care expenses* which are excludable as income according to *Code* § 105(b). *Qualified medical flexible spending expenses* may not be otherwise reimbursable under the *benefit plan* or other plan or by any other entity, and they may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

What are examples of qualified and non-*qualifying flexible spending expenses?*

The examples listed in this section are intended only to give you a convenient reference to the types of expense that may be eligible for reimbursement. Determination of *qualified medical flexible spending expenses* will be in accordance with those expenses *incurred* for medical care, as defined in *Code* § 213(d) of the Internal Revenue Code as stated at the time the expense was *incurred*.

Examples of *qualified medical flexible spending expenses* include:

- Acupuncture
- Alcoholism treatment
- Allergy tests and shots
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical condition
- Blood pressure monitoring devices
- Blood sugar kits and test strips
- Birth control pills
- Birth prevention surgery
- Braille materials (books and magazines)
- Chiropractic services
- Christian Science practitioner fees
- Co-payments
- Contact lenses and supplies
- Crutches
- Deductibles on your and your spouse's group plan
- Dental services (not cosmetic)
- Dentures
- Elastic bandages
- Eyeglasses, including examination fees
- First aid kits
- Flu shots and other immunizations
- Healing services

- Hearing aids and batteries
- Hospital costs not covered by a group health plan
- Insulin
- Laboratory fees
- Laetrile (by prescription)
- Laser eye surgery and radial keratotomy
- Mental health care and fees
- Nonprescription drugs and medicines that are health care expenses and in some cases with a prescription
- Nurses' fees
- Obstetrical expenses
- Orthopedic shoes prescribed by a physician
- Oxygen
- Physician, podiatrist, and osteopath fees not covered by medical plan
- Prescription drugs
- Prosthesis
- Radial keratotomy
- Ramps required by medical conditions
- Rehabilitation therapies, including speech therapy, physical therapy, and occupational therapy
- Rental of medical equipment
- Routine physical examinations
- Seeing eye dogs and their upkeep
- Smoking cessation programs, only if monitored by a licensed practitioner
- Special communications equipment for the deaf
- Sterilization procedures
- Therapeutic are for substance abuse (drug or alcohol)
- Weight loss programs prescribed by physicians for specific health problems
- Wheelchairs

Examples of *non-qualified medical flexible spending expenses* include:

- Cosmetic surgery, except those procedures necessary to improve a deformity arising from, or directly related to, a congenital abnormality, or personal injury resulting from an accident or trauma, or a disfiguring disease
- Funeral expenses
- Health insurance premiums
- Massage therapy, except for massages recommended by a physician to treat a specific injury or trauma
- Maternity clothes
- Nursing home expenses
- Weight loss programs prescribed by physicians for general health improvement

This list should not be considered all-inclusive, and determination of non-qualified expense will be in accordance with Internal Revenue *Code* §§ 105(b) and 213(d) as stated at the time the expense is *incurred*.

Over-the-Counter Drugs or Medicine

Effective January 1, 2011, medical care expenses eligible for reimbursement under the *Plan* shall include expenses for medicines or drugs incurred after December 31, 2010 only if the medicine or drug is a prescribed drug or medicine (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The *Plan Administrator* shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied. The *Plan Participant* must provide documentation that the item was prescribed. Generally, this will be a receipt for the medicine or drug that includes a prescription number.

Qualified dependent care flexible spending expenses

If you have elected to contribute to a *dependent care flexible spending account*, the *Plan* will reimburse you for *qualified dependent care flexible spending expenses* which are *incurred* by you during the *plan year*.

Reimbursement for *qualified dependent care flexible spending expenses* is limited to the annualized amount you elected under your *salary reduction agreement* to contribute to a *qualified dependent care flexible spending account* for the *plan year*. It is important to keep in mind that you cannot use amounts contributed to a *qualified medical flexible spending account* to pay *qualified dependent care flexible spending expenses*.

What are *qualified dependent care flexible spending expenses?*
Qualified dependent care flexible spending expenses are employment-related *dependent* care expenses eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e) (1) and 21(b). Such expenses include amounts paid for daycare and other household services and for the care of *qualifying individuals* enabling you to be gainfully employed.

What are examples of qualified and non-*qualified dependent care spending expenses?*
The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of eligible expenses will be in accordance with Code §§ 21 and 129, as stated at the time the expense is *incurred*.

Examples of *qualified dependent care flexible spending expenses* include:

- Fees of a licensed dependent care center that cares for your *dependent* child.
- After-school care expenses.
- Wages of individuals who provide care inside or outside your home for your *dependent* child under age 13 or a *qualifying individual* over age 13 who is incapable of self-support.
- Federal and state employment taxes you pay for an individual you employ to provide dependent care.
- Day camps.
- Pre-school or nursery school tuition.

Examples of non-*qualified dependent care flexible spending expenses* include:

- Educational expenses for a child in first grade or above.
- Transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.
- Household expenses that are not attributable at least in part to the care of the *qualifying individual*.
- Expenses for a camp where a *qualifying individual* spends the night.

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with *Code* §§ 21 and 129, as stated at the time the expense is *incurred.*

Benefit costs
By electing to participate in the *premium only plan*, your portion of the *benefit costs* will be taken out of your salary and paid using pre-tax dollars.

Must I file a claim for benefits under the *premium only plan*?
No, it is not necessary to file a claim for benefits under a *premium only plan*. Amounts taken out of your pay pursuant to a *salary reduction agreement* will automatically be used to pay your benefit costs.

How do I file a claim for benefits under a *qualified medical flexible spending account*?
You must submit a properly completed and documented claim to:

HealthSCOPE Benefits
P. O. Box 8071
Little Rock, AR 72203

It must include the following information:

- The name of the person or persons on whose behalf the expenses have been *incurred*.
- The nature of the expenses *incurred* (that is, a description of the services or supplies being claimed).
- The date the expenses were *incurred.*
- Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any *benefit plan*, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letter9s) from the *benefit plan*(s). Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved the *Plan Administrator* certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are reimbursement under the *Plan*.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

How do I file a claim for benefits under a *qualified dependent care flexible spending account*?
You must submit a properly completed and documented claim to:

HealthSCOPE Benefits, Inc.
P.O. Box 8071
Little Rock, AR 72203

It must include the following information:

- A list of names of the eligible *qualifying individual* for whom the expenses were incurred, the ages of such *qualifying individual*, and the *qualifying individual's* relationship to you.
- If any of the services were performed outside of your home for a *qualifying individual* incapable of caring for him or herself, a statement as to whether the *qualifying individual* regularly spends at least eight hours a day in your home.
- If any of the services are performed for a *qualifying individual* who is physically or mentally incapable of caring for himself or herself, a statement to that effect.
- A description of the nature and date of performance of the qualifying services for which cost you wish to be reimbursed.
- A description of the relationship, if any to you of the person or persons who performed the services
- A statement indicating that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt *dependent care facility*) the taxpayer identification number of the provider of the services.
- If you are married, and your *spouse* is employed, a statement of your spouse's compensation.
- If you are married and your *spouse* is not employed, a statement that your *spouse* is incapacitated, or that your *spouse* is a *student*, and indicating the months of the year during which the *spouse* attends an educational institution of a full-time basis.
- A statement as to the amount, if any, of tax-exempt *dependent* care assistance benefits received from any other employer for you or your spouse during the *plan year*.
- Evidence of indebtedness or payment by you to the third party who performed the services.

- Written evidence, signed by an independent third party stating that the expenses have been *incurred*, the amount of such expenses, the date of services, and such other information as the *Plan Administrator* in its sole discretion may request.
- A statement as to where the services were performed.
- A statement indicating whether the services are necessary to enable you to be gainfully employed.
- A statement that the expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- A statement, signed by you and is such form as determined by the *Plan Administrator*, certifying that the expenses for which reimbursement is sought are expense that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care provider or from the individual who provides the care. The social security number of the federal tax identification number of the provider **must** appear on the claim form or receipt. The individual who provides the care cannot be your *spouse* or a *dependent* under the age of 19.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

Is there a time limit for filing claims?
All claims for reimbursement must be submitted with in 90 days following the end of the *plan year* or earlier, or the claims will be denied.

What if my *qualified medical flexible spending account* balance or my *qualified dependent care flexible spending account* balance is less than my claim?
Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the *qualified medical flexible spending* account for the *plan year* under a valid *salary reduction agreement*. Reimbursements for *qualified dependent care flexible spending expenses* is limited to the amount that you have elected to reduce your salary or wages to contribute to the *qualified dependent care flexible spending account* for the *plan year* under a valid *salary reduction agreement* for that *plan year.*

To the extent that it is not used to pay claims, the amount of contributions to your *qualified dependent care flexible spending account* will also accumulate throughout the plan year. If you submit an eligible claim during the *plan year* in an amount that exceeds your current *qualified dependent care flexible spending account balance, the Plan* will reimburse your claim expense up to the total amount of contributions in your *qualified dependent care flexible spending account*, less any amounts already used to pay claims. As contribution amounts become available in your *qualified dependent care flexible spending account,* they may be used to reimburse any unpaid balance from a previously submitted *qualified dependent care flexible spending expense*. At no time during the *plan year* will the amount paid for claims exceed the amount of contributions made to the *qualified dependent care flexible spending account.*

In no instance can amounts contributed to a *qualified medical flexible spending account* be used to reimburse *qualified dependent care flexible spending expenses*, or vice versa.

May I withdraw any or all of the balance of qualified medical flexible spend account for expenses other than qualified medical expenses?
No. The only exception to this rule is for qualified reservist distributions.

What if I do not use all of the money in my *qualified medical flexible spending account or my qualified dependent care flexible spending account?*

You have 90 days after the end of the *plan year* to file any *qualified medical flexible spending expenses and qualified dependent care flexible spending expenses incurred* for that year. If you fail to file for reimbursement within this time limit, or if you did not incur enough *qualified medical flexible spending expenses or qualified dependent care flexible spending expenses* to meet your annual salary contribution amount to each respective account, you forfeit any unused funds in your account.

FUNDING

How is a *qualified medical flexible spending account* funded?

Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary reduction agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary reduction agreement.*

Your annual salary or wage may be reduced in an amount not to exceed $5,000 and a minimum of $260. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The Plan will reimburse you for *qualified medical flexible spending expenses* as described in the "Benefits" section.

How is a qualified dependent care flexible spending account funded?

Your *qualified dependent care flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary reduction agreement*. *Qualified dependent flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary reduction agreement.*

Your salary or wage may be reduced in an amount you elected under the *salary reduction agreement*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified dependent care flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The Plan will reimburse you for *qualified dependent care flexible spending expenses* as described in the "Benefits" section.

How much can I elect to contribute to my *qualified dependent care flexible spending account?*

If you are not married you may contribute up to $5,000 to a *qualified dependent care flexible spending account;* however, in the event that your *earned income* is less than $5,000, you may contribute an amount not to exceed your *earned income* for the taxable year. If you begin participation in the middle of the *plan year* you may contribute up to $5,000, or $2,500 if you and your spouse file separately, less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year*.

If you are married, you may contribute an amount up to the lesser of the *earned income* of you or your *spouse*, not to exceed $5,000. If you and your *spouse* file separate tax returns, you may elect to contribute an amount up to $2,500 to *the Plan*. If you begin participation in the middle of the *plan year* you may contribute to up to $5,000, or $2,500 if you and your *spouse* file separately, less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year.*

If your *spouse* is a full-time student, for each month in which he or she is a full-time student, for the purpose of determining how much you can contribute under this plan, he or she will be considered to be gainfully employed, and to have *earned income* of not less than $250 per month if there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than $500 per month is there are two or more *qualifying individuals* with respect to the taxpayer for the taxable year.

If your spouse is a *qualifying individual*, for the purpose of determining how much you can contribute under this plan, he or she will be considered gainfully employed, and to have *earned income* of not less than $250 per month if there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than $500 per month if there are two or more *qualifying individual* with respect to the taxpayer for the taxable year.

How is a premium only plan funded?

The *premium only plan* is funded by your contributions under a *salary reduction agreement* with the participating employer. The contribution amounts paid under the *salary reduction agreement* will be adjusted automatically during a *plan year* to reflect changes in the benefit cost.

Order of funding

The total salary contribution amount for this *Plan* for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: *the premium only plan, the qualified medical flexible spending account, then the qualified dependent care flexible spending account*. The total salary contribution amount will be reduced by the amount is exceeds your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting

The *Plan Administrator* will maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of *qualified medical flexible spending expenses or qualified dependent care flexible spending expenses* on behalf of each *participant*. All contributions will be held as part of the general assets of the participating employer. No trust fund will be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this *Plan*.

SALARY CONTRIBUTION AND DISCRIMINATION

Election period for salary contribution

In order to fund a *qualified medical flexible spending account, qualified dependent care flexible spending account*, or the *benefit costs* for a *premium only plan* for a *plan year*, you must complete and file with the *Plan Administrator* or an appropriate *salary reduction agreement* election form as described in the section, "Eligibility for Participation." You should consider carefully the amount of salary contribution you elect for each account because you will forfeit any unused amount at the end of the year *plan year*.

Termination, revocation, or amendment of salary contribution elections

Your *salary reduction agreement* election for a *plan year* will terminate at the end of the *plan year*. You must make an affirmative election for a new salary contribution for each *plan year*. However, with regard to the *premium only plan* only, once you have elected to participate in a *premium only plan*, your participation will continue from *plan year to plan year* unless you affirmatively elect to cancel or change that participation by completing the appropriate *salary reduction agreement.*

Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, "Eligibility for Participation," "May I make mid-year changes?"

Forfeiture of salary contribution amounts

If you fail to claim any amounts in the *qualified medical flexible spending account, qualified dependent care flexible spending account, or premium only plan* with the time limits specified in the section, "Benefits", "Is There a Time Limit for Filing Claims?", such amounts will be forfeited by you to the *Plan Sponsor*.

Reduction of salary contribution elections to prevent discrimination in favor of prohibited group(s)

The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits and is intended to comply in this respect with the requirements of the *Code*. If in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *plan year* would result in such discrimination, then the *Plan Administrator* shall select and exclude from coverage under the *Plan* such highly compensated individuals who are *participants*, and/or reduce contributions under the *Plan* by highly compensated individuals who are participants, to the extent necessary to assure that, in the judgment of the *Plan Administrator*, the *Plan* does not discriminate.

The *Plan Administrator* will have the full authority to reduce the salary contribution elections of *participants* who are members of the prohibited group(s) under *Code* §§ 105(h) or 125, to the extent necessary to prevent the *Plan* from discriminating in favor of such prohibited group(s).

Determination of noncompliance

In the event that a determination is made that all or any part of the contributions to the *Plan* do not qualify as non-taxable contributions to a "cafeteria plan" under *Code* § 125, the affected contributions made by any participant will be treated as salary, and any unpaid balance in the *qualified medical flexible spending expense account, the qualified dependent care flexible spending account and the premium only plan* will be returned to the *participant*. The *participant* must pay:

- Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed;
- The *participant's* share (as determined in good faith by the participating employer) or any applicable FICA or FUTA contributions which would have been withheld from such amounts by the participating employer had such amounts been treated as salary and not as *qualified medical flexible spending expense, qualified dependent care flexible spending expenses, or benefit costs;* and
- An amount (as determined in good faith by the *participating employer*) equal to the portion of any applicable penalties and interest payable by the *participating employer* as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the *participant*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the Plan?

The *Plan Administrator* has retained the services of the *third party administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are not *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses, or benefit costs)*, to decide disputes which may arise relative to a *participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a *third party administrator* to pay claims;
- To perform all necessary reporting;
- To establish and communicate procedures to determine whether *MCSOs* and *NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

May changes be made to the Plan?

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with the applicable federal and state law. In the even that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of the *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor.*

Additional operating rules

A *participant's* salary contribution amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary contribution amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

Salary contribution amounts under this *Plan* shall not reduce salary or wage for purposes of any other employer sponsored employee benefit programs unless the provisions of those programs otherwise provide.

MISCELLANEOUS INFORMATION

Will the *Plan* release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the privacy standards. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision. See HIPAA Privacy Practices on page 31.

What if the Plan make an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that is has determined that the *Plan Administrator* has mistakenly reimbursed an expense which did not qualify under the terms of the *Plan*, the *Plan Administrator* may adjust your pay and appropriately credit the *qualified medical flexible spending account, qualified dependent care flexible spending account or premium only plan.*

What if the employee makes an error?

In the case of an employee mistake, a correction will only be allowed as permitted by law.

Will the Plan conform with applicable laws?

This *Plan* shall be deemed automatically to be amended to conform as required by an applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*.

What constitutes a fraudulent claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this *Plan.*

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your *spouse* or your *dependent* according to the *Plan*;
- Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan* or;
- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?

The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Participants* are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this *summary plan description* applies to *participants*.

How may a Plan provision be waived?

No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the on specifically waived.

Is this *summary plan description* a contract between the employer and *participants*?

This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *participating employer* and any *participant* or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this *summary plan description* shall be deemed to give any employee the right to be retained in the service of the *participating employer* or to interfere with the right of the *participating employer* to discharge any employee at any time.

May I appoint an authorized representative?

A *participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator*. In the event a *participant* designates an authorized representative, all future communications form the *Plan* will be with the representative, rather than the *participant*, unless the *participant* directs the *Plan Administrator,* in writing, to the contrary.

How will the *Plan* pay benefits?

All benefits under this *Plan* are payable, in U.S. dollars, to the *participant* or, if appropriate, the alternate recipient. In the event of the death or incapacity of a *participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, the *Plan Administrator* may, in its sole discretion, make any and all payments due under the plan to the individual or institution which, in the opinion of the *Plan Administrator*, is or was providing the care and support of such *participant*.

What if my claim is for non-U.S. providers?

Qualified medical flexible spending expenses and qualified dependent care flexible spending expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "*non-U.S. provider*") may be reimbursed under the following conditions:

- The *participant* is responsible for making all payments to *non-U.S. providers*, and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all requirements under *Code* § 105; and
- Claims for benefits must be submitted to the *Plan* in English.

How will the Plan recover payments made in error?

Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* on whose behalf such payment was made.

A *participant, spouse, dependent,* provider, another benefit plan, insurer, or any other person or entity who receives a payment made in error under the terms of the *Plan*, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum, payroll deduction, or other arrangement.

Participants accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with the requirements of this *Plan*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* shall be entitled to recover its litigation costs and actual attorney's fees incurred.

How will the Plan handle medical child support orders?
The *Plan Administrator* shall adhere to the terms of any *medical child support order* that satisfies the requirements of this section. The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any alternate recipient who is the subject of a *medical child support order* that is *qualified medical support order* if such an individual is not already covered by the *Plan* as a *dependent*.

The *Plan Administrator* shall promptly notify the *participant* and each alternate recipient of:
- The receipt of a *medical child support order* by the *Plan;* and
- The *Plan's* procedures for determining the qualified status of *medical child support orders*.

Within a reasonable period after receipt of a *medical child support order*, the *Plan Administrator* shall determine whether such order is a *qualified medical child support order* and shall notify the *participant* and each alternate recipient of such determination. If the *participant* or any affected alternate recipient disagrees with the determinations of the *Plan Administrator*, the disagreeing party shall be treated as a claimant and the claims procedure provided in the section, "Claims Review Procedures," of the *Plan* shall be followed. The *Plan Administrator* may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the *Plan*.

Upon receiving a national medical support notice, the *Plan Administrator* shall:
- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the *Plan*, and if so:
    - Whether the child is covered under the *Plan*;
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

    To give effect to this requirement, the *Plan Administrator* shall:
    - Establish reasonable, written procedures for determining the qualified status of a *medical child support order or a national medical support notice*; and
    - Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the order.

Payments under this *Plan* pursuant to a *medical child support order* described in this section in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial or legal guardian.

Will the *Plan* provide a statement of benefits?
Throughout the *plan year*, the *Plan Administrator* will provide access to a web-based online system to each *participant* who received benefits under the *Plan* which will show the amounts paid or the expenses incurred by the *Plan Sponsor* in providing reimbursement under the *Plan* for *qualified dependent care flexible spending expenses, qualified medical flexible spending expenses, and benefit costs* for the prior *plan year.* In the fourth quarter, the Plan will mail a statement outlining funds not yet used.

Upon receipt of complete information, the claim will be deemed to be filed with the *Plan*. The *third party administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *third party administrator* within 45 days from receipt by the participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of claims decisions

The *Plan Administrator* shall notify you, in accordance with the provisions set forth below, of any adverse benefits determination within the following timeframes:

- If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the plan Administrator.

Extensions. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notified you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an adverse benefit determination

The *Plan Administrator* shall provide you with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *summary plan description* upon which a denial is based;
- Specific reason(s) for denial;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of you right to bring a civil action under section 502(a) of *ERISA* following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits';
- The identity of any medical or vocational experts consults in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to you, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, or a statement that such explanation will be provided to you, free of charge, upon request.

Appeal of adverse benefit determinations

Full and fair review of all claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this Plan proved you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in while or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advise was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances.

Requirements for appeal

You must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, you appeal must be addressed and mailed as follows:

HealthSCOPE Benefits
P. O. Box 2860
Little Rock, AR 72203

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *participant;*
- The *participant's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the participant has which indicates that the participant is entitled to benefits under the *Plan*.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of notification of benefit determination on review

- The *Plan Administrator* shall notify you of the *Plan's* benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of an appeal.

- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and content of notification of adverse benefit determination on review

The *Plan Administrator* shall provide you with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the *summary plan description* on which the denial is based;
- The identify of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the *participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, protocol, or other similar criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, will be provided free of charge upon request;
- The following statement: "You and your Plan *may* have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing documents in the event of an adverse determination

In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide you access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on review to be final

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 180 days after the Plan's claim review procedures have been exhausted.**

The following is a description of certain uses and disclosures that may be made by the *Plan* regarding your health information. If you receive benefits under the *Plan*, this Privacy Notice explains the rights you have with respect to your health information, and certain obligations the *Plan* must abide by in accordance with the law.

Nothing contained in this Privacy Notice should be construed to supersede or limit any additional rights you may be entitled to under other applicable law. Therefore, if an applicable law affords you greater rights or more protections other than as described herein, the *Plan* will comply with the law that gives you greater rights and/or protections.

The *Plan* is required to abide by the terms of this Privacy Notice, but reserves the right to make additional changes to this Privacy Notice and to make such changes applicable to all of your health information that it maintains. If the *Plan* makes any material revisions to this Privacy Notice, it will provide you with a copy of the revised Privacy Notice which will specify the date on which such revised Privacy Notice becomes effective.

I. Use and Disclosure of Your Health Information

The *Plan* component in which you are enrolled may use your health information for treatment, payment and health care operations. The *Plan* may also use your health information for other purposes that are permitted and/or required by law and pursuant to your written authorization. The following lists examples of how the *Plan* may use and/or disclose your health information. Any other uses or disclosures not described in this Privacy Notice will only be made with your explicit written authorization, which authorization you may revoke at any time by providing the *Plan* with written notice of your revocation.

A. For Treatment.

The *Plan* may disclose your health information to a health care provider that provides treatment to you. For example, in an emergency situation, the *Plan* may provide your health care provider with information regarding the type of prescription drugs you are currently taking if necessary for your proper treatment.

B. For Payment.

The *Plan* may use your health information to obtain premium payments or to fulfill its responsibility for coverage and the provision of benefits under the *Plan*. For example, the *Plan* may receive and maintain information about a health care service you received in order to process a claim from a physician for reimbursement for services provided to you.

C. For Health Care Operations.

The *Plan* may also disclose your health information for management functions. For example, the *Plan* may use and/or disclose your health information to evaluate its performance or to conduct or arrange for legal services and audit functions, including fraud and abuse detection and compliance programs. Additionally, the *Plan* may use your health information for its business management and general administrative activities, including but not limited to: (i) management activities relating to implementation of and compliance with law; (ii) customer service; (iii) resolution of internal grievances; (iv) the sale, transfer, merger, or consolidation of all or part of the *Plan* with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and (v) creating de-identified information or a limited data set.

D. For Treatment Alternatives.

The *Plan* may use and disclose your health information to tell you about treatment options or alternatives that may be of interest to you.

E. For Health-Related Benefits and Services.

The *Plan* may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you.

F. To Family Members, Relatives or Close Friends.
Unless you object to such disclosure, the *Plan* may disclose your health information to your family members, relatives or close personal friends, or any other person identified by you as being involved in your treatment or payment for your medical care. If you are not present to agree or object to the *Plan* 's disclosure of your health information to a family member, relative or friend, the *Plan* may exercise its professional judgment to determine whether the disclosure is in your best interest. If the *Plan* decides to disclose your health information to your family member, relative or other individual identified by you, the *Plan* will only disclose the health information that is relevant to your treatment or payment.

G. To Business Associates.
The *Plan* may disclose your health information to its "business associates." Third party administrators, auditors and consultants are some examples of business associates of the *Plan* .

H. Other Permitted and Required Uses and Disclosures.
In some cases, the *Plan* may use your health information without obtaining your authorization and without offering you the opportunity to agree or object as follows:

- as required by law, provided however, that the use or disclosure will be made in compliance with applicable law;
- to a public health authority that is authorized by law to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority;
- to a health oversight agency for oversight activities authorized by law, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions;
- to a public health authority or to a government authority authorized by law to receive reports of abuse, neglect or domestic violence;
- for judicial or administrative proceedings;
- for law enforcement purposes;
- to a coroner or medical examiner to perform duties authorized by law;
- to funeral directors, consistent with applicable law, as necessary to carry out their duties;
- to organ procurement organizations or similar entities for the purpose of facilitating organ, eye or tissue donation and transplantation;
- for research purposes;
- to avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such threat;
- for specialized government functions, such as the proper execution of a military mission or national security activities;
- to a correctional institution or law enforcement custodian;
- to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault; and
- to the *Plan Sponsor* as permitted by law.

II. YOUR RIGHTS AS A PARTICIPANT IN THE PLAN
As a *participant* in the *Plan*, you have a number of rights associated with your health information. The following describes your specific rights.

A. The Right to Request a Restriction or Limitation on the Use and Disclosure of Your Health Information.
You have the right to request restrictions or limitations on how the *Plan* is allowed to use and/or disclose your health information; however, the *Plan* does not have to agree to your requested restriction or limitation. If you would like to request a restriction or limitation on the *Plan's* use or disclosure of your health information, please send your written request to the address listed at the end of this Privacy Notice. Your request must specify: (1) if you would

like to restrict or limit *Plan's* use, disclosure or both; (2) what information you would like to restrict or limit; and (3) to whom you want the limitation or restriction to apply (e.g., your spouse).

If the *Plan* agrees to a restriction or limitation of your health information, the restriction or limitation will not prevent the *Plan* from disclosing your health information as follows: (1) to you if you request access to your health information or if you request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to workers' compensation); or (3) in the case of an emergency, as described below.

If the *Plan* accepts your restriction or limitation regarding how the *Plan* may use or disclose your health information, the *Plan* may nevertheless disclose the restricted health information to a health care provider if you are in need of emergency care and your restricted health information is needed to provide emergency treatment to you. Before the *Plan* discloses your restricted health information to a health care provider during an emergency, the *Plan* will require the health care provider that receives your health information to not further use or disclose your health information. If the *Plan* accepts your requested restriction or limitation, it may terminate the restriction or limitation if: (1) you agree to the termination or request the termination in writing; (2) you orally agree to the termination and the oral agreement is appropriately documented; or (3) it informs you that it is terminating the restriction or limitation; provided, however, the *Plan's* termination would only be effective for health information the *Plan* creates or receives after it informs you of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations.
You have the right to request receipt of health information from the *Plan* by alternative means or via alternative locations provided that you clearly state that the disclosure of all or part of your health information could endanger you. For example, you may want to receive communications related to your health care at a different address other than your home address because you could be in danger of harm if someone at that address saw your health information. If you wish to receive confidential communications via alternative means or locations, please submit your written request to the address listed at the end of this Privacy Notice and set forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications.

C. Right to Inspect and Copy Your Health Information.
You have the right to inspect and obtain a copy of your health information; provided, however, you are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 ("CLIA") to the extent your access is prohibited by law, or is exempt from CLIA. If you would like to access your health information, please send your written request to the address listed at the end of this Privacy Notice. If the *Plan* does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. If you request a copy of your health information, you will receive a response to your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, the *Plan* may deny your request for access to health information. For example, the *Plan* may deny access to health information that is subject to the Privacy Act. The *Plan* may also deny you access to health information if such information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. If your request is denied for one of these reasons, you will not have the opportunity to review the denial.

Additionally, the *Plan* may deny you access to health information if: (1) access is reasonably likely to endanger the life and physical safety of you or someone else; (2) the access requested refers to another person and your access is reasonably likely to cause substantial harm to such other person; or (3) you are the personal representative of another individual and a health care professional determines that your access is reasonably likely to cause substantial harm to the individual or another person. If you are denied access for one of these reasons, you are entitled to review by a health care professional, designated by the *Plan*, who was not involved in the decision to deny access. If access is ultimately denied, you will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures.
You have the right to receive an accounting of disclosures of your health information made by the *Plan*, including disclosures to or by business associates of the *Plan* , for the period of six years prior to the date on which you request an accounting of disclosures, or such lesser period as you indicate; provided, however, you are not entitled to receive an accounting of disclosures for disclosures that occurred prior to April 14, 2004. If you would like to receive an accounting of disclosures, please send your written request to the address listed at the end of this Privacy Notice. If the *Plan* does not have your health information in its possession, it will provide you with the appropriate contact information when it receives your request. You will receive a response to your request for an accounting of disclosures no later than sixty days after your request is received.

Notwithstanding the foregoing, your accounting of disclosures will not include any disclosures made: (1) to carry out treatment, payment and/or health care operations; (2) directly to you; (3) incident to a use or disclosure otherwise permitted by law; (4) pursuant to your authorization; (5) to persons involved in your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2004.

You will receive one request annually free of charge and, thereafter, the *Plan* may charge you a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same twelve-month period. The *Plan* will notify you of the cost for an accounting of disclosures and you may choose to withdraw or modify your request before it charges you for any costs.

E. Right to Amend Your Health Information.
If you believe the *Plan* has health information about you that is incorrect or incomplete, you may make a written request to the *Plan* stating the reasons to support your requested amendment. You have the right to request an amendment to your health information for so long as the *Plan* maintains your health information. If you would like to amend your health information, please send your written request to the address listed at the end of this Privacy Notice. If the *Plan* does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. You will receive a response to your request for an amendment no later than sixty days after the *Plan* receives your request. However, the *Plan* may deny your request for amendment if, for example, the *Plan* determines that it did not create your health information or your health information is already accurate and complete. You may respond to a denial by the *Plan* by filing a written statement of disagreement, but the *Plan* has the right to rebut your disagreement. If this occurs, you have the right to request that your original request, the *Plan's* denial, your statement of disagreement, and the *Plan's* rebuttal be included in future disclosures of your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice.
You have the right at any time to obtain a paper copy of this Privacy Notice, even if you receive this Privacy Notice electronically. If you have received an electronic copy of this Privacy Notice, but would like to obtain a paper copy of this Privacy Notice, please send your written request to the address listed at the end of this Privacy Notice.

III. MISCELLANEOUS

A. Complaints.
If you believe your privacy rights have been violated, you may file a complaint with the *Plan* or with the Secretary of the Department of Health and Human Services. If you would like to file a complaint with the *Plan* , please forward your written complaint to the address listed at the end of this Privacy Notice. If you choose to file a complaint, the *Plan* is prohibited by law from retaliating against you for filing such complaint.

B. Effective Date.
This revised notice is effective as of January 1, 2012.

C. Contact Information.
If you need any additional information about this Privacy Notice, please contact, the Privacy Officer at: County of El Paso; 800 E. Overland, Suite 223, El Paso, TX 79901.

IV. DISCLOSURE OF ELECTRONIC PROTECTED HEALTH INFORMATION ("ELECTRONIC *PHI*") TO THE *PLAN SPONSOR* FOR PLAN ADMINISTRATION FUNCTIONS

In accordance with *HIPAA's* Security Standards for the Protection of *Electronic PHI (*the "*Security Standards*"), and to enable the *Plan Sponsor* to receive and use *Electronic PHI* for plan administration functions, the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the *Electronic PHI* that creates, received, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504 (f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides *Electronic PHI* created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the *Electronic PHI*;
- Report to the *Plan* any Security Incident of which it becomes aware;
- Notify *participants* of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18); and
- Notify the Federal Trade Commission of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18).

Any terms not otherwise defined in this section shall have the meanings set forth in the *Security Standards.*