Southern State Community College

HEALTH REIMBURSEMENT ARRANGEMENT
(HRA2 – Opt-Out Credit for Waiver HRA)

Plan Document and Summary Plan Description

Effective: April 01, 2019
Restated: January 01, 2024

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Southern State Community College** (the "Company" or the "Plan Sponsor") as of **January 01, 2024**, hereby sets forth the provisions of the Southern State Community College Health Reimbursement Arrangement (the "Plan"), which was originally adopted by the company, effective April 01, 2019, and which is an opt-out credit for waiver Health Reimbursement Arrangement integrated with the Southern State Community College Medical Plan or other group health insurance plan that provides minimum value ("Benefit Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Southern State Community College

By: _____

Name: STEVEN HINSHAW

Title: VP FINANCE

Date: 1-25-24

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Only Participants who meet the conditions below can become Participants under this Plan.

- Employee has waived group health insurance coverage under Employer's employer-sponsored group health plan for him or herself.
- Employee has employee-only coverage under Employer's employer-sponsored group health plan (because of the spouse's employer's spousal carve out rule), but waives coverage for his or her Dependents
- Employee and/or Employee's Dependents have coverage under his or her spouse's employer's group health insurance plan (or any other group health insurance plan) that provides minimum value.

Please note: Employee and/or Employee's Dependents are ineligible for this Plan if Employee is covered by Medicare, Medicaid, TRICARE, or an individual health insurance policy.

The purpose of this Plan is to allow the Participating Employer to provide contributions to reimburse Employees and their eligible Dependents for eligible medical expenses under this Plan and Code § 213(d), with such contributions to be excluded from said Employees' gross income for tax purposes pursuant to Code § 106. Among other conditions, expenses which are eligible under this Plan are limited to those which are not covered under some other health plan or provided by the Employer.

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **Southern State Community College** and may be reviewed at any time during normal working hours by any Participant.

The Benefit Plan

While the terms Plan and Benefit Plan are used in this document to distinguish between the Health Reimbursement Arrangement, described herein, and the Benefit Plan, for the purposes of ERISA as well as the Internal Revenue Service, this Health Reimbursement Arrangement and the Benefit Plan shall be deemed to constitute one plan.

General Plan Information

Name of Plan:
Southern State Community College Health Reimbursement Arrangement HRA2

Plan Sponsor:
Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

Plan Administrator
(Named Fiduciary):
Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

Plan Sponsor ID No. (EIN):
31-0858297

Source of Funding:
Self-Funded

Applicable Law:
ERISA and applicable IRS Code Sections

Calendar Year:
January 1 through December 31

Plan Number:
501

Plan Type:
Health Reimbursement Arrangement

This integrated HRA is intended to qualify as a self-funded employer-provided medical reimbursement plan for purposes of §§ 105 and 106 of the Internal Revenue Code and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective.

Claims Administrator:
Custom Design Benefits
5589 Cheviot Road
Cincinnati, OH 45247
Phone: 1-513-598-2929
Fax: 1-513-389-3699
Email/Website: www.customdesignbenefits.com

Participating Employer(s):
Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

Agent for Service of Process:
Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded exclusively with Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 et seq. or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates (where applicable):

1. The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2. The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3. The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4. The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5. The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6. The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7. The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8. The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

"Benefit Plan"
"Benefit Plan" means the Southern State Community College Medical Plan, which was established and is maintained by the Plan Sponsor for the purpose of providing health benefits to eligible Participants.

"Calendar Year"
"Calendar Year" shall mean the 12-month period from January 1 through December 31 of each year.

"Claims Administrator"
"Claims Administrator" shall mean the claims administrator which provides customer service and claims reimbursement services.

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

"Code"
"Code" shall mean the Internal Revenue Code of 1986, as amended.

"Coverage Period"
"Coverage Period" shall mean, in most cases, the Plan Year. For Participants who enroll at any time other than the beginning of the Plan Year or Participants who terminate during the Plan Year, the Coverage Period is the time these Participants are eligible under this Plan.

The Plan Administrator may determine a different Coverage Period provided Participants are informed of such determination.

"Dependent"
"Dependent" shall mean an individual who qualifies as a Dependent under, and participates in, the Benefit Plan.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved drug or medicine that is listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution - Federal Law prohibits dispensing without prescription," or a State

restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a physician and/or duly licensed provider. "Drug" shall also mean insulin for purposes of injection.

"Employee"
"Employee" shall mean an Employee who meets the eligibility requirements of, and participates in, the Benefit Plan.

"Employer"
"Employer" is Southern State Community College.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Health Reimbursement Account"
"Health Reimbursement Account" shall mean the recordkeeping account established to track the contributions and available reimbursement amounts for each Participant. Such account is maintained by the Plan Administrator. Each covered Employee's Health Reimbursement Account shall also include the total contribution and reimbursement amounts for that covered Employee's Dependents who also participate in the Plan. The Plan Administrator will establish and maintain a Health Reimbursement Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose.

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

"Participant"
"Participant" shall mean an Employee or Retiree who has become eligible for benefits under this Plan and has not ceased to be a Participant in the Plan.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Prescription"
"Prescription" shall mean a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the health care expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Qualified Medical Expense(s)"
"Qualified Medical Expense(s)" shall mean medical and/or Prescription Drug expenses incurred by a Participant while participating in this Plan, provided that such expenses are:

1. Defined in Code § 213(d).
2. Are not contributions to the group health plan or for qualified long-term care insurance.
3. Are not otherwise reimbursable under the Benefit Plan or by any other health benefit plan.

With the exception of insulin, the Plan will not reimburse Participants for the cost of any medicines or drugs which are not prescribed, regardless of whether the medicine or drug can be acquired without a Prescription.

Participants will not be reimbursed for any expenses which are incurred outside of the applicable Coverage Period or Plan Year, incurred before or after the Participant is eligible to participate and receive benefits under the Plan, have been deducted from the Participant's taxes in the preceding tax year, or are otherwise covered or payable by any other source.

"Retiree"
"Retiree" shall mean a retired former employee of the Employer.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE; TERMINATION OF COVERAGE

Eligibility for Coverage

Each Employee or Retiree will become eligible for coverage under this Plan on the date such Employee satisfies the conditions of eligibility as follows:

- Employee has waived group health insurance coverage under Employer's employer-sponsored group health plan for him or herself.
- Employee has employee-only coverage under Employer's employer-sponsored group health plan (because of the spouse's employer's spousal carve out rule), but waives coverage for his or her Dependents
- Employee and/or Employee's Dependents have coverage under his or her spouse's employer's group health insurance plan (or any other group health insurance plan) that provides minimum value.

Please note: Employee and/or Employee's Dependents are ineligible for this Plan if Employee is covered by Medicare, Medicaid, TRICARE, or an individual health insurance policy.

Qualified Medical Child Support Orders

If a child is subject to a "medical child support order" or a "national medical support order" that is a "qualified medical child support order," as defined by applicable law, that child shall automatically be eligible to receive benefits under this Plan if otherwise eligible.

Effective Dates of Coverage; Conditions

If properly enrolled, coverage under this Plan will become effective simultaneously with coverage under the Benefit Plan.

When a Participant becomes eligible to participate in the Plan and properly enrolls, the Plan will establish a Health Reimbursement Account in the Participant's name. The Participant will be entitled to receive reimbursement from this account for Qualified Medical Expenses incurred by the Participant and the Participant's Dependents (if eligible) - but only if such persons are covered under the Benefit Plan. The Participant may receive reimbursement for Qualified Medical Expenses incurred at a time when he or she is actively participating in the Plan. The amount of reimbursement for Qualified Medical Expenses is limited to the remaining balance in the Participant's account.

Termination of Coverage

Participation in this Plan terminates simultaneously with the termination of participation in the Benefit Plan or when this Plan terminates (whichever is earlier).

When a Participant ceases to be eligible, the Participant will not be able to receive reimbursements for Qualified Medical Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Qualified Medical Expenses incurred during the Coverage Period prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim within 90 days following the close of the Plan Year in which the Qualified Medical Expense arose.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Family and Medical Leave Act (FMLA) Leave

If the covered Employee's participation in the Benefit Plan continues while he or she is on FMLA Leave, his or her participation in this Plan shall continue.

The Plan shall at all times comply with FMLA if applicable. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage During Uniformed Services Employment and Reemployment Rights Act (USERRA)

If the covered Employee's participation in the Benefit Plan continues while he or she is on USERRA leave, his or her participation in this Plan shall continue.

Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

If a Participant is eligible for COBRA under the Benefit Plan, he or she is eligible for COBRA under this Plan.

Notwithstanding any provision in this Plan or the Benefit Plan to the contrary, Qualified Beneficiaries (the Participant along with any Dependents), whose coverage terminates under the Plan as a result of a COBRA qualifying event, shall be given the opportunity to continue coverage, on a self pay basis, to the extent required and for the periods prescribed by COBRA, including applicable conditions and limitations.

COBRA is a federal law that gives certain Employees, an Employee's spouse, or Dependent children the right to temporary continuation of their health care coverage under the Employer's medical or other health insurance plan at group rates. If the Participant incurs an event known as a "Qualifying Event", and if such individual is covered under this Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his coverage under this Plan if he or she pays the applicable premium contribution for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his health insurance coverage. A Qualifying Event includes the following events:

- Termination from employment or reduction of hours;
- Divorce or legal separation;
- Becoming eligible to receive Medicare;
- A Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. The Participant is responsible for informing the Employer of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation of coverage shall be for a period of 36 months.

A contribution for COBRA continuation coverage shall be charged to Qualified Beneficiaries, which shall be payable at such times and in such amounts as established by the Plan Administrator and permitted by COBRA.

Additional Information

For additional information regarding all applicable leave and continuation coverage options, please contact the Plan Administrator:

Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

Rehire

If a terminated Employee is rehired, he or she will be reinstated in this Plan in the same manner and with the same effective date as set forth in the Benefit Plan.

BENEFITS

Health Reimbursement Benefits

The Plan will reimburse Participants for Qualified Medical Expenses up to the unused amount for each Participant.

This Plan will reimburse Qualified Medical Expenses for Employees, spouses and Dependent children. Qualified Medical Expenses only include expenses eligible for reimbursement under the Benefit Plan but not reimbursed under that plan because of the application of that plan's single or family deductible requirement.

This Plan will reimburse Qualified Medical Expenses for Employees, spouses and Dependent children.

A Participant's Health Reimbursement Account will be credited at the beginning of each Calendar Year with the amount of $7,850 for single coverage and $15,700 for family coverage. The amount available for reimbursement of Qualified Medical Expenses is the amount credited to the Participant's Health Reimbursement Account reduced by prior reimbursements debited.

HRA Payment Information:

Amount of primary plan's Deductible that must be met prior to HRA Payment will be:	
Single	$1,600
Employee + Spouse	$3,200
Employee + Child(ren)	$3,200
Family	$3,200

Once the HRA deductible liability has been satisfied, the HRA will pay:	
Maximum Benefit per Coverage Period:	
Single	$7,850
Employee + Spouse	$15,700
Employee + Child(ren)	$15,700
Family	$15,700

If any balance remains in the Participant's Health Reimbursement Account after all reimbursements have been made, such balance shall be forfeited. However, expenses incurred after an individual ceases to be a Participant under the Plan will not be reimbursed unless COBRA continuation coverage is elected and otherwise available.

Changes

For subsequent Calendar Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees in accordance with ERISA.

Nondiscrimination

Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator in its sole discretion.

Establishment of Health Reimbursement Account

The Claims Administrator will establish and maintain a Health Reimbursement Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The Health Reimbursement Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

Crediting of Accounts

A Participant's Health Reimbursement Account will be credited at the beginning of each calendar month during a Coverage Period with an amount equal to the applicable maximum dollar limit for the Coverage Period divided by the number of months in that Coverage Period (e.g., divided by 12 in a 12-month Plan Year). No amount shall be credited for a calendar month, however, if the Participant is not still an eligible Employee on the first day of that calendar month. (So, for example, a Participant will not receive a credit for a month if the Participant is not also a participant in the Benefit Plan for that month.)

Debiting of Accounts

A Participant's Health Reimbursement Account will be debited during each Coverage Period for any reimbursement of Qualified Medical Expenses incurred during the Coverage Period.

Available Amount

The amount available for reimbursement of Qualified Medical Expenses is the amount credited to the Participant's Health Reimbursement Account reduced by prior reimbursements that are debited.

Coordination of Benefits; Health Flexible Spending Account (FSA) to Reimburse Second

Benefits under this Plan are intended to reimburse only Qualified Medical Expenses which are not reimbursable from any other source. If another source is available to reimburse an otherwise eligible Qualified Medical Expense, this Plan will reimburse said expense only as secondary to any and all available other sources with the exception of a health Flexible Spending Account (FSA). This Plan will pay before the Employer's FSA (if applicable).

Qualified Medical Expenses

Qualified Medical Expenses are health care expenses which are excludable as income according to Code § 213(d). Qualified Medical Expenses may not be otherwise reimbursable under the Benefit Plan or by any other health benefit plan or by any other entity, and they may not be claimed as a tax deduction.

The Plan Administrator's determination of eligible expenses will be in accordance with Code § 213(d) as stated at the time the expense is incurred.

For the purposes of this Plan, the following types of expenses are reimbursable:

1. Deductible(s).
2. Copayments.
3. Coinsurance.
4. Rx - Prescription Drugs

For the purposes of this Plan, the following documentation will be accepted as proof of payment for reimbursement:

1. Explanation of Benefits (EOB) from Primary Carrier
2. Online statements from Primary Carrier showing single and family accumulators
3. Bag receipts for prescriptions
4. Pharmacy printouts for prescriptions

Exclusions; Non-Qualified Medical Expenses

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code §213 and may otherwise be reimbursable under IRS guidance pertaining to Health Reimbursement Arrangements:

1. Any item that does not constitute "medical care" as defined under Code §213(d).
2. Any essential health benefit, as defined by the ACA, that is not covered by any health benefit plan.
3. Automobile insurance premiums.
4. Bottled water.
5. Cosmetics, toiletries, toothpaste, etc.
6. Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
7. Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
8. Custodial care.
9. Funeral and burial expenses.
10. Health plan contributions for any other plan (including the Benefit Plan). (Notwithstanding the foregoing, the Health Reimbursement Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer).
11. Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
12. Long-term care services.
13. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
14. Massage therapy.
15. Over-the-counter drugs and medicines without a Prescription, except as required by the Families First Coronavirus Response Act ("FFCRA"), as amended.
16. Salary expense of a nurse to care for a healthy newborn at home.
17. Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
18. Transportation expenses of any sort, including transportation expenses to receive medical care.
19. Uniforms or special clothing, such as maternity clothing.
20. Vitamins.
21. Weight loss programs prescribed by a physician for general health improvement.

FUNDING

Benefits Offered

Benefits under this Plan shall be offered in the form of reimbursements for Qualified Medical Expenses out of a Health Reimbursement Account, and shall never be provided in any other form.

Contributions

The Employer funds the full amount of the Health Reimbursement Accounts. Participant contributions to participate in this Plan will only be required as provided herein in the case of COBRA coverage. Under no circumstances will benefits be funded under a cafeteria plan.

Funding this Plan

Plan benefits are funded solely from the general assets of the Plan Sponsor. The Employer and the Plan Administrator are not required to, and do not, maintain any distinct fund or segregate amounts for the benefit of specific Participants. No Participant or other person shall have any claim or other interest in any fund, account or asset of the Employer from which payment may be made under this Plan.

In no event shall the Plan Administrator reimburse Qualified Medical Expenses in an amount greater than the balance available in the Participant's Health Reimbursement Account as of the time the claim is submitted.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Claims Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect 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 will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes that may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for reimbursement, to review claim denials and appeals relating to them and to uphold or reverse such denials.

7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Claims Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, 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 or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Qualified Medical Expenses incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Definitions

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

"Claimant"
"Claimant" shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.
The availability of health benefit payments is dependent upon Claimants complying with the provisions of this Plan described herein:

Written proof that expenses eligible for Plan reimbursement and/or payment were incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Reimbursement Procedure

Claims Submission and Substantiation
A Claimant who seeks benefits may apply for reimbursement by submitting a claim for reimbursement in writing to the Plan in such form as the Plan may prescribe (either paper or electronic), by no later than 90 days following the close of the Calendar Year in which the Qualified Medical Expense was incurred, setting forth:

1. The individual(s) on whose behalf Qualified Medical Expenses have been incurred.
2. The nature and date of the Qualified Medical Expenses so incurred.
3. The amount of the requested reimbursement.
4. A statement that such Qualified Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source, and that Health Flexible Spending Account (FSA) coverage, if any, for such Qualified Medical Expenses has been exhausted.

The application shall be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Qualified Medical Expenses have been incurred and the amounts of such Qualified Medical Expenses, together with any additional documentation that the Plan may request.

Claims should be submitted to:
Custom Design Benefits
5589 Cheviot Road
Cincinnati, OH 45247
Phone: 1-513-598-2929
Fax: 1-513-389-3699
Email/Website: www.customdesignbenefits.com

Receiving Reimbursement

If the claim is approved, the Employer will reimburse the Claimant for his or her claim for Qualified Medical Expenses on a regular basis, as determined by the Employer.

Claims in Excess of the Employee's Account
If an Employee submits a claim for more than the current balance of the Health Reimbursement Account, the Employee's claim will be paid up to the balance available in his or her Health Reimbursement Account.

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

1. If the Claimant has 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.
2. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
3. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant 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 the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

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 notifies the Claimant, 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 a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three (3) days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. The identity of any medical or vocational experts consulted 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).
8. 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 the Claimant, free of charge, upon request).
9. 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 the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

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 the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

4. 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.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole 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.
7. The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for Appeal

The Claimant must file an appeal regarding a reimbursement claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Custom Design Benefits
5589 Cheviot Road
Cincinnati, OH 45247
Phone: 1-513-598-2929
Fax: 1-513-389-3699
Email/Website: www.customdesignbenefits.com

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

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. 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 Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.

6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides 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 the Claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal. ***NOTE:*** *This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.*

The period of time within which the Plan's determination is required to be made shall begin at the time an 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 a Claimant with notification in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
4. The identity of any medical or vocational experts consulted 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).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. 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 the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. 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 such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant 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.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO.
4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Two Levels of Appeal

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

Fraud

It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Employee and eligible dependents who are Participants under this Plan.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

No Guarantee of Tax Consequences

It is the sole obligation of each Participant to determine whether any payment under this Plan is excludable from their gross income for federal, state, or local tax purposes. Although certain tax treatment of Plan benefits is expected and desired, it is not guaranteed that any particular tax consequence result from participation in the Plan or that amounts paid as Plan benefits will be excludable from the Participant's gross income as applicable. Additionally, the Participant must notify the Plan Administrator if he or she has any reason to believe that such payment is not so excludable.

No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's

general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Third Party Recovery, Subrogation and Reimbursement

This Plan will follow the third party recovery, subrogation, and reimbursement procedures of, and has the rights set forth in, the Benefit Plan.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

If applicable, whenever payments have been made by this Plan in a total amount, at any time, in excess of the amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made.

HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 1-937-393-3431.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. For health care operations.
3. For treatment purposes.
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Establish safeguards for information, including security systems for data processing and storage.
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
6. Not use or disclose genetic information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528).
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware.
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections.
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
    b. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off

without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
    c. Locate and notify persons of recalls of products they may be using.

d. A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he or she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he or she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse,

or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes.
2. Uses and disclosures for marketing.
3. Sale of PHI.
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy

Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.

7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:
Privacy Officer
Southern State Community College
100 Hobart Drive
Hillsboro, OH 45133
Phone: 1-937-393-3431

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. 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.
3. 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 administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach notification must be provided to the affected individual(s) by:
    a. Written notice by first-class mail to the Participant (or next of kin) at the last known address or, if specified by the Participant, e-mail.

b. If the Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form".
c. If an urgent notice is required, the Plan may contact the Participant by telephone. The breach notification will have the following content:
    i. Brief description of what happened, including date of breach and date discovered.
    ii. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number).
    iii. Steps the Participant should take to protect from potential harm.
    iv. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.