FLEXIBLE BENEFIT CAFETERIA PLAN

Summary Plan Description (SPD)
As of May 1, 2020

Mississippi State University
P.O. Box 9603
Mississippi State, Mississippi 39762

Modified: May 1, 2020

Introduction.

This Summary Plan Description describes the basic features of a Flexible Benefit Cafeteria Plan (the Plan). It is an employee benefit program offered for you and your fellow employees. Under federal tax laws, it is known as the "Cafeteria Plan." It lets you choose from several different insurance and fringe benefit programs according to your individual needs. Through your Employer, you are offered the opportunity to use pre-tax dollars to pay for the eligible benefits offered by entering into a salary reductions arrangement instead of receiving the corresponding amount of your regular pay. The benefits you elect are non-taxable, saving you income taxes.

This Summary Plan Description (SPD) will describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. This is not the official plan document. If there is a conflict between the plan document and this summary booklet, the plan document will prevail.

Each Participant, and each beneficiary receiving benefit(s) under the Cafeteria Plan, shall be furnished this SPD, including any material modifications to the terms and change in information required to be included in the SPD. Your employer (the "Employer") is the Plan Sponsor of your Plan.

Purpose of the Plan.

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reductions to pay for certain benefits under the Plan with pre-tax dollars. Pre-tax Contributions elections as described in this Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

Becoming a Participant.

An Election and Salary Reduction Agreement will be made available to you as a new hire and during the scheduled open enrollment period. You will be given the opportunity during this period to elect eligible coverage as a new hire, or for the following Plan Year. Prior to each subsequent Plan Year, you will be given the opportunity to change your benefit election. If you fail to complete and return a new election form within the regular enrollment period, preceding each Plan Year, your election will remain the same, unless your Employer has a requirement for a new election form and you will be notified.

Certain Benefit Participation options may be adopted by your Employer, for the Plan, and are outlined in the Plan Information Summary identifying your Plans Benefits and Participation requirements or options. With exceptions to those certain benefit options, (as outlined in the Plan Information Summary), you become a participant by signing an Election and Salary Reduction Agreement (SRA) on which you elect one or more of the benefit(s) available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You must complete and return your manual form or electronic enrollment form, within the time period specified by the Plan Administrator. If you do not elect coverage when you are first eligible, you will have to wait until the next open enrollment period to enroll for the following Plan Year.

A new Election and Salary Reduction Agreement will be made available to you during the open enrollment period, and you will be given the opportunity during this period to elect your coverage for the following Plan Year. Prior to each subsequent Plan Year, you will be given the opportunity to change your benefit election.

You must select eligible coverage within the time period specified by the Plan Administrator. If you do not elect coverage when you are first eligible, you will have to wait until the next open enrollment period to enroll for the following Plan Year, unless you have a qualifying Change in Status, as outlined in Change in Status.

Example of Savings.

You save federal income tax, state income tax and Social Security taxes by participating in the Plan. The following is an example of tax savings you might experience as a result of participating in the Premium Payment Plan.

Cafeteria Illustration.

WITHOUT PARTICIPATION IN CAFETERIA	WITH PARTICIPATION IN CAFETERIA
$1,000 GROSS SALARY/W-2 INCOME	**$1,000 GROSS SALARY**
-300 TAXES (STATE, FED, SOC. SEC.)	**-100 INSURANCE &/OR OTHER EXPENSES**
700 NET CHECKS	**900 NET CHECKS/W-2 INCOME**
-100 INSURANCE &/OR OTHER EXPENSES	**-270 TAXES (STATE, FED, SOC. SEC.)**
$ 600 NET SPENDABLE INCOME	**$ 630 NET SPENDABLE INCOME**

Notice of Enrollment Rights.

If you have declined enrollment for yourself and/or dependents when you were hired, you may enroll in the Cafeteria Plan, during the open enrollment period (generally within sixty (60) days prior to your plan year renewal effective date) or you may enroll yourself and/or your dependents in this Flexible Benefit Cafeteria Plan, provided that you request enrollment within ninety (90) days from an event of a Change in Status. See Change in Status discussed below.

Election Changes during the Plan Year.

Generally, you cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year. The only exception to this general rule would be in a case of a "Change in Status" as described below. Certain exceptions apply for Participants in Unreimbursed Medical Spending Accounts, as defined in Unreimbursed Medical Spending Plans and Termination, in the Plan Information Summary.

Additionally, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual, (as defined by the Internal Revenue Code), as necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law, and adjustments may also be made to reflect insignificant mid-year premium increases imposed by third party insurers.

Change in Status.

You may revoke, change or make a new election, provided that the revocation or election change is caused by, and consistent with, a "Change in Status." The request for change must be consistent with the event. Your Plan Administrator (in its sole discretion) determines if it is within prevailing IRS guidelines. Examples of permissible changes that qualify as a Change in Status are listed below:

- a change in your legal marital status (such as marriage, divorce, annulment or death of your spouse);
- a change in the number of dependents (such as birth, adoption or placement for adoption of a child or the death of a dependent);
- a change of employment status by you, your spouse, or your dependent (such as a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in employment status, the effect of which is a loss of eligibility to participate in the Plan or any Benefit Plan available hereunder and changes due to the Family Medical Leave Act (FMLA));
- a reduction or increase in your hours of employment, spouse or dependent;
- your dependent's satisfying or ceasing to satisfy an eligibility requirement for a particular benefit, such as attaining a specified age or ceasing to be a student;
- certain Judgments and Orders or Entitlements to Medicaid or Medicare;
- gain of coverage eligibility under another Employer's Plan by your spouse's or dependent's employment;
- a qualifying unpaid Uniformed Services Leave, to the extent required by Uniformed Services Employment and Reemployment Rights Act, (USERRA); and/or an adult child that is no longer eligible to participate in any insurance, due to age restrictions. Under the Affordable Care Act, (ACT) Participants may offer health insurance coverage to a child, until he/she reaches the age of twenty-six (26). Both married and unmarried children qualify for this coverage. Therefore, once they attain age twenty-six (26), the Participant would be eligible for Status Change. If the child is not on the Parents' plan and loses coverage, the dependent child may enroll in the parents' plan; provided the child has not yet attained the age twenty-six (26), and the parents may allow the Adult Childs out-of-pocket qualifying expenses for Unreimbursed Medical, until they attain the age of twenty-seven (27);
- a change in your insurance premium deductions due to cost or coverage changes in your Spouse's or Dependent's employment. For instance, if you spouse has a rate increase through his/her employer, you may add your spouse to your coverage.

Special Enrollment Rights.

You may make a change if your spouse or dependent is entitled to special enrollment rights under a group health plan, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under Code § 9801(f). A Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment rights. (Applies only to Premium Payment Plans, does not apply to Health Flexible Spending Account "Health FSA" or Dependent Care Account Plans (DCAP) Benefits.) Including the Children's Health Insurance Program Reauthorization Act of 2009, which extends and expands the state Children's Health Insurance Program (CHIP) allowing for additional special enrollment rights for eligible individuals under the following two circumstances:

(1). The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee request coverage under the Employer's health plan within sixty (60) days after the termination, or

(2). The Employee or Dependent becomes eligible for a premium assistance under Medicaid or CHIP, and the Employee request coverage under the plan within sixty (60) days after eligibility is determined.

The Children's Health Insurance Program Reauthorization Act of 2009 will now allow the dropping health coverage, when eligibility of CHIP is met; this is effective April 1, 2009 and after.

PLAN INFORMATION SUMMARY

1. Flexible Benefit Plan Information:

The Employer named below establishes a Flexible Benefit Cafeteria Plan (the Plan), as outlined in this Summary Plan Description (SPD), as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees with Cafeteria Plan benefit choices, within the meaning of Section 125 of the Internal Revenue Code.

- **Mississippi State University**, Flexible Benefit Cafeteria Plan, is the name of the Plan.
- The provisions of the Plan described herein initially became effective on April 1, 1987;
- And as Amended on May 1, 2020.
- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on January 1, and ends on December 31.
- Your Employer's tax identification number is 64-6000819.

2. Employer Information:

Your Employer's name, address and telephone number is:

Mississippi State University
P.O. Box 9603
Mississippi State, Mississippi 39762
Telephone: (662) 325-3713

3. Plan Administrator Information:

The name, address, and business telephone number of your Plan Administrator is:
Nancy Siegert,
Chief Human Resources Officer
Mississippi State University
P.O. Box 9603
Mississippi State, Mississippi 39762
Telephone: (662) 325-3713
Attention: Cafeteria Plan Administrator

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determination of facts, and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

4. Plan Service Provider:

Southern Administrators and Benefit Consultants, Inc., (SABC)
P.O. Box 2449
Madison, Mississippi 39130-2449
(662) 856-9933
www.sabcflex.com

The Plan Service Provider shall provide standard Cafeteria Plan Services for the Plan and adjudicate all Flexible Spending Plan claims for Cafeteria Plan reimbursements.

5. Eligible Benefit Plan and Provider:

(a). **Benefit Plans or Policies**

Group Term Life Insurance – State of Mississippi Group Term Life Plan
Group Health Insurance – State of Mississippi Group Health Plan
Dental Insurance – Delta Dental
Vision Insurance – Davis
Accident Insurance, Critical Care – AFLAC
Cancer & Specified Disease – AFLAC
AD&D – AIG, ICU – AFLAC, Cancer/ICU CCU & Dread Disease – Central United (Renewal Only)

Upon meeting the Plans eligibility requirements defined in section 9 below, the eligibility for coverage under any given "Benefit Plan or Policies" listed above, shall be determined by the terms of the Benefit Plan or Policy. Salary reduction of the Participant's compensation, to pay pre-tax or after-tax contribution(s), shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

All Benefit Plans or Policies elected require mandatory participation under the Plan and any fees associated with Participation will apply. This means if you elect any eligible Benefit Plan or Policy coverage outlined in 5) "Eligible Benefit Plan and Provider" above, you automatically become a participant in the Plan weather or not you complete and sign an Election and Salary Reduction Agreement (SRA). By your purchase of the Benefit you are agreeing to a salary reduction to pay for those benefits elected.

Flexible Spending Plans.

An eligible Employee may become a Participant in the Dependent Care and/or Unreimbursed Medical Expense Reimbursement Plan(s).

(b). **Dependent Care Spending Account.**

Described in this SPD, (as defined in Publication 503), shall not to exceed $5,000 per a Calendar Plan Year, or $2,500 per Calendar Plan Year for married individual, filing a separate tax return; pursuant to the Dependent Care Expenses Reimbursement Plan requirements.

(c). **Unreimbursed Medical Spending Account.**

The maximum amount of reimbursement for Unreimbursed Medical Spending Account expenses incurred by the Participant shall be no more than **$2,650 (**as indexed for inflation/cost-of-living adjustments), per Plan Year. Benefits offered, as described in the Plan Benefits are:

- The Unreimbursed Medical Plan offers the Carryover Provision;
- The Unreimbursed Medical Plan includes a SABCFlex Card (Electronic Payment Card), as a "prescription only" card; for all qualifying medical expenses;
- The Unreimbursed Medical Plan Benefit Period does not include the Grace Period.

6. Run Out Period:

This is a Benefit Period Run out time, that provides you with the opportunity to spend down or submit, your previously incurred (incurred during your Plans, Benefit Period), Unreimbursed Medical and/or Dependent Care Spending Plan expenses. All Unreimbursed Medical and/or Dependent Care Spending Plans will have thirty (30) days, following the date of your termination, or following the end of the Benefit Period, (ending on April 15th), during which you may submit a claim for reimbursement for a qualified benefit incurred during the Plan.

7. HIPAA Responsible Persons; Privacy Officer and Security Officer:

The name and address of the Plan's Privacy and Security Officer are:

Nancy Siegert,
Chief Human Resources Officer
Attention: HIPAA Security Office

Juli Rester,
Senior Compensation & Benefits Manager
Mississippi State University
P.O. Box 9603
Mississippi State, Mississippi 39762
Attention: HIPAA Privacy Office

The names of the Responsible Person(s), in accordance with HIPAA, that may have access to your PHI:

Plan Administrator – Nancy Siegert, Chief Human Resource Officer

HIPAA Privacy Officer – Juli Rester – Senior Compensation & Benefits Manager

HIPAA Security Officer - Nancy Siegert, Chief Human Resource Officer

8. Service of Legal Process:

The name and address of the Plan's agent for service of legal process is:
Nancy Siegert,
Chief Human Resources Officer
Mississippi State University
P.O. Box 9603
Mississippi State, Mississippi 39762
Attention: Cafeteria Plan Administrator

9. Who Can Participate in the Plan?

All Employees must be working full-time, (-20-) hours or more per week in a position that is anticipated to exceed 4 and ½ months in duration, and must complete (-0-) days of service to be eligible to participate in the Plan.

10. Administrative Cost.

There is no administrative cost incurred by you for participating in the Cafeteria Plan, as your Employer pays for this benefit.

11. Is my Plan an ERISA Plan?

This Plan qualifies as a Non-ERISA Plan, as defined in ERISA Rights. Items listed in this SPD, which are not listed in the Plan Information Summary, or are noted as "does not offer", are not an option for this plan and/or is not offered in your Cafeteria Plan.

PLAN BENEFITS

Premium Payment Plan.

When you become a Participant, your eligible premiums will be paid with that portion of gross income that you have elected to forgo through pre-tax salary reductions.

Unreimbursed Medical Spending Accounts (URM) Benefit.

If you elect benefits under this portion of the Plan, an Unreimbursed Medical Spending (URM) Account will be set up in your name to keep a record of the reimbursements to which you are entitled, as well as the premiums you have paid for such benefits during the Plan Year. Your URM Account is merely a record keeping account; it is not funded (all reimbursements are paid from the general assets of the Employer).

You may elect any amount you desire, subject to the maximum as defined in the Plan Information Summary, and you will be required to pay the annual premium equal to the coverage level you have chosen.

When you complete the Election and Salary Reduction Agreement, you specify the amount of URM you wish to pay for with your salary reduction. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium deducted from each paycheck, except in the case of Termination. The full amount of the coverage you have elected will be available to reimburse you for eligible Medical Expenses at any time during the Plan Year. For example, suppose that you have made a Plan Year election of $1,200 URM Expenses, and that you have chosen no other benefits under the Cafeteria Plan. Your Account would be credited with a total of $1,200 during the Plan Year. If you are paid monthly, your Account would reflect that you have paid $100 ($1,200/12) per pay period in premiums for the benefit you elected.

A "Medical Expense" generally means an item for which you could have claimed a Medical Expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed from insurance or from some other source.

Section 213(d)(1) defines "medical care" to include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Below are a few examples of Medical Expenses that ARE NOT allowed:

- Over-the-counter "OTC" drugs and/or dietary supplements (vitamins), food supplements, toiletries, cosmetics, sundry items, pain relievers, cold or allergy medicine, cough suppressants, toothache/teething medication, liniments, antacids and other similar OTC medicines;
- health insurance premiums that you or your spouse pay for coverage under another Health Plan;
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body to prevent or treat illness or disease;
- expenses for weight loss diet foods, including OTC weight loss drugs;
- massage therapy, health club dues, or fitness programs; and
- any medical related expense that you are not required to pay.

Unreimbursed Medical Benefit Period.

Medical expenses must have been incurred, meaning the services must be rendered during Unreimbursed Medical Benefit Period. "Unreimbursed Medical Benefit Period" means the period of coverage for Unreimbursed Medical Spending Account, to begin the date of the Employees participation in the Unreimbursed Medical Spending Plan and for a period not to exceed beyond the Plan Year ending date. (Exceptions apply for Plans that adopt the Grace Period, as defined in the Plan Information Summary). Plan Year-end reimbursement claims must be submitted to the Plan Administrator within the Run-Out period (as defined in the Plan Information Summary) in order to be eligible for reimbursement. You may not be reimbursed for any expenses arising before the Plan becomes effective, before your Salary Reduction Agreement or amendment became effective, or for any expenses incurred after the close of the Unreimbursed Medical Benefit Period. You are entitled to receive your total election for any eligible unreimbursed medical expense incurred during your Unreimbursed Medical Benefit Period.

a) Grace Period. Your Plan may include a Grace Period, (as defined in the Plan Information Summary). A Grace Period is an optional period following the end of the Plan Year, extending your benefit period for incurring expenses, by 2 ½ months, ending on the fifteenth (15^{th}) day of the third month, following the close of the Plan Year. If adopted by your Employer, would allow you, during this time, to incur Unreimbursed Medical expenses and have those funds reimbursed from the closing Plan Year.

   The Grace Period ensures that you have the opportunity to maximize your URM funds and avoid forfeiting money through the IRS required "use-it-or-lose-it" rule. (The "use-it-or-lose-it rule" is defined by IRS, meaning FSA Participants must use their account funds for eligible expenses before the benefit period ends. Unused FSA funds are forfeited at the end of the plan year). For plans with the Grace Period option, you should still carefully estimate your planned expenses based on a standard Plan Year (twelve [12] month) period and make a conservative election based on that estimate.

   The Grace Period is meant to help you when your expenses fall a little short of expectations. It is not an extension of the plan year, and you may not increase in your URM election amount during this period. You may submit claim(s) incurred during the Grace Period, and have them be first reimbursed from any remaining balances in the previous Plan Year; claims incurred during this period, will always be applied to the remaining balance in the previous Plan Year first, until that balance is exhausted; only then will claims be applied to the new Plan Year funds.

Dependent Care Spending Account Benefits.

Under the Dependent Care Spending Account, you are provided with a source of pre-tax funds to reimburse yourself for Eligible "Dependent" Care Expenses. By entering into a Salary Reduction Agreement with your Employer, you agree to a salary reduction to fund Dependent Care Expenses in lieu of your regular pay.

If you elect benefits under this portion of the Plan, a Dependent Care Spending Account will be set up in your name to keep a record of the reimbursements to which you are entitled. Your Dependent Care Spending Account is merely a record keeping account; it is not funded (*all reimbursements are paid out of the general assets of the Employer*).

Your election cannot exceed the maximum amount specified in §129 of the Internal Revenue Code. The maximum amount is currently $5,000 per Plan Year if you:

- are married and file a joint return; or
- are married, and furnish more than one-half of the cost of maintaining your dependents; your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate return; or
- are single and head of the household for tax purposes.

If you are married and reside with your spouse, but you file a separate federal income tax return, then the maximum Dependent Care you may elect is $2,500 per Calendar Year.

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care benefits you wish to pay with your salary reduction. Thereafter, your Dependent Care Spending Account will be credited with the portion of your gross income that you have elected to forgo through salary reduction. These portions will be credited each pay period. The amount that is available for reimbursements at any particular time will be the amount that has been credited to your Dependent Care Spending Account, less any reimbursements already paid.

For example, suppose you have elected $2,400 for Dependent Care Expenses and you have chosen no other benefit under the Employer's Cafeteria Plan, your Dependent Care Spending Account, would be credited (and funded) with a total of $2,400 during the Plan Year. Thus, if you are paid monthly, you would have a total of $200 credited to your Dependent Care Spending Account each payday to pay reimbursements under this Plan.

Dependent Care expenses must meet *all* of the following conditions for them to be eligible Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of your election, and during the Plan Year to which it applies;
2. Each individual for whom you incur the expenses is;
   (a) a dependent under age thirteen (13) and is entitled to a personal tax exemption; or
   (b) a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself;
3. The expenses are incurred for the care of a dependent (as described above), to enable you and/or your spouse to be gainfully employed;
4. The expenses cannot be paid to another dependent of yours who is under age nineteen (19) or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent;

"Dependent(s)" means any individual who is a tax dependent of the Participant as defined in Code §152(a) and as amended by Working Families Tax Relief Act (WFTRA) of 2004 (FS-2005-7, January, 2005). You are encouraged to consult your personal tax advisor and/or IRS Publication 502, "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense.

You will be required to file IRS Form 2441, or a similar form, with your annual federal income tax return, listing the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your Dependent Care Expenses may be eligible for the dependent care credit.

Dependent Care expenses may be eligible as a tax credit if not elected under your Employer's Cafeteria Plan. The tax credit may benefit you more than your Cafeteria Plan depending on your household income. Consult your tax advisor to determine which will offer you a greater benefit.

Claims Procedures for reimbursements under Flexible Spending Plans (FSA) Unreimbursed Medical (URM) and Dependent Care Spending Accounts.

When you incur an expense that is eligible for reimbursement, you must submit a claim to the Plan's Service Provider, on a Claim Form or Request for Reimbursement Form, provided on their web site. This form may be used as an electronic submission form or you may obtain a manual form to print and complete. Upon completion of the required form, you must provide substantiation of the expense, which must be supplied by a third party provider. For Unreimbursed Medical Spending Account Expenses, you must include written statement(s)/bills(s) with the Medical Provider's name and address, date of service (not date paid), and the service type and cost of the Eligible Expense, after all third party payments or discounts have been applied. Medical bill(s) or receipts must also include the Patient's Name. Prescription drugs must include the Patient's Name, the Name of the Drug and the RX number on the receipt along with the information above. A cash register receipt only, does not provide this information. Only eligible expenses not reimbursed by insurance or any other means, (i.e., health insurance, supplemental insurance, Health Reimbursement Arrangements, and/ or Health Savings Accounts). Benefits could be limited based on other benefit coverage(s) and their plan design. An Explanation of Benefits or "EOB(s)" may be required to determine if an expense has been paid by a third party.

When claiming Dependent Care Expenses, you must include the care provider's tax identification number or social security number, the dependent's name, date of birth, amount of the expense, and the period of coverage. Once again, the expense must be incurred during the Plan Year. If you have enough funds in your Dependent Care Spending Account, you will be reimbursed for your eligible expenses. Funds are available after payroll deductions have been made and the Plan's Service Provider has received a credit of those funds from your Employer.

If the claim you submit is more than your current Dependent Care Spending Account Reimbursement Account balance, then the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate.

Claims are generally processed the same day for URM. Dependent Care Reimbursements, however, are based on individual funds deposited. Funds for Dependent Care are generally available a few days after payroll has been made. You may fax, mail or email claims through SABC encrypted online claim portal. No claims or Protected

Health Information (PHI), may be accepted through regular email. Once claim verification has been completed, reimbursements are issued generally by direct deposit, mail or pick up.

The Plan Service Provider is not responsible for direct deposit account errors due to misinformation, or direct deposit rejections due to a Participants closed bank account, or any bank errors or closures beyond our control. The Plan Service Provider does not assume responsibility for any "Non-Sufficient Funds service fee(s);" known as NSF fee(s), as may be charged by the Participant's bank/financial institution, due to any delayed credits at the fault of the bank/financial institution, rejected deposit; resulting in an NSF charge, or charges incurred due to NSF. There is a $15.00 minimum on all reimbursements issued as a manual check; unless it is at the close of the Plan Year.

All reimbursements are based on eligible claims incurred by the Participant, or the Participant's qualifying individuals and/or dependents, within the meaning of Code Sec. 213(d) for medical care and §129 for dependent care. Any amounts determined paid in error (e.g., payments to a Participant that should not have received payment, as determined by the Plan Administrator and the documentation provided), the plan permits recovery of the error payment.

Forfeiture of Unclaimed Reimbursement Account Benefits.

Participants in a Spending Account must use contributions during the benefit period outline in the plan. Funds remaining at the end of the benefit period (excluding certain eligible URM balances that may be rolled on Carryover plans), will be forfeited. (See your Plan Information Summary for details). This rule is commonly referred to as the "use-it-or-lose-it" rule, requiring that unused contributions or benefits remaining at the end of the plan year be forfeited to the employer.

Coverage under the Dependent Care Spending Account will terminate as of the day you are no longer employed by the Employer or your contribution has been missed for any reason. However, you may submit claims during the run-out period, for reimbursement of Eligible Employment-Related Expenses. Unclaimed funds, (e.g., un-cashed benefit checks) remaining in your Dependent Care Spending Account after the run-out period, will be forfeited.

Claim Denials.

You will be notified by the Plan's Service Provider within thirty (30) days of the date the Plan's Service Provider received your claim for Unreimbursed Medical and/or Dependent Care Spending Reimbursement Accounts if your claim is denied in whole or in part. Such notification will set out the specific reasons your claim was denied with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and what steps, if any, you might take in order to validate the claim. (This time period may be extended for an additional fifteen [15] days for matters beyond the control of the Plan's Service Provider, including cases where a claim is incomplete and the Participant has received a denial.) The Plan's Service Provider will provide notice of any extension, including the reasons for the extension.

Where a claim is denied or incomplete, an extension notice will also specifically describe the required information needed and will allow you forty-five (45) days from receipt of the notice in which to provide the specified information. This will have the effect of suspending the time for a decision on your claim until the specified information is provided. If the Plan's Service Provider fails to respond within fifteen (15) days of receipt of your claim, your claim is treated as denied. You, your beneficiary or your authorized representative

have a right to request, in writing, an administrative review of the denial, at anytime within a sixty (60) day period after you received notification of the denial. Any such request should be accompanied by documents or records as instructed by your first denial to support your appeal.

You, your beneficiary or your authorized representative will have the opportunity to review any important documents held by the Plan's Service Provider, and to submit comments and other supporting information. In most cases, a decision will be reached within sixty (60) days of the date of your request for a review and a written response to the appeal will be provided.

Within sixty (60) days after you receive written notification of the denial (in whole or in part) of your claim, you or your beneficiary or your authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage pre-paid, to be afforded a review of such denial; may review pertinent documents; and may submit issues and comments in writing.

Upon receipt of a request for review, the Plan Administrator shall make a prompt decision, provided in writing, and shall specify reasons for the decision and specific references to the pertinent plan, rules, or insurance policy provisions on which the decision was based. This decision on review shall be made within sixty (60) days of your request for a review. If the Plan Administrator requires an extension, the Plan Administrator will provide you with a written notice of the extension prior to the expiration of the reviews initial sixty (60) days. You will have one hundred-eighty (180) days to file an appeal to the decision after receipt of denial notification.

Effects Participation has on Social Security and other Benefits.

Your participation may reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security Benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation.

FMLA and USERRA.

If your Employer is subject to the Family and Medical Leave Act (FMLA), (refer to your Human Resources Department), you may be able to continue your insurance coverage on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra salary reductions before you go on leave). If you are on a leave during the annual enrollment period, and wish to make changes to your FSA, you may do so only when you return to work on a regular basis (as a benefits-eligible employee) certifying that the qualified life event occurred and that you satisfy any other conditions required for you to make the election change you request.

For the Uniformed Services Employment and Reemployment Rights Act, (USERRA), the Plan complies with specific plan and contract provisions, as well as federal and state laws regarding military leaves. If you take a military leave of absence, are called to active military duty, or are reassigned to another military duty station,. If you are receiving a paycheck your regular contributions will continue. When you go on unpaid leave, you will be required to make monthly contributions. For URM, your contributions continue on a before-tax basis. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred only during the time you made contributions. Claims that you incur after the last day of the last pay period in which you made contributions are not eligible for reimbursement. Once you no longer receive a paycheck, if you wish to continue your FSA, you can continue with after-tax contributions through COBRA for the remainder of the plan year. If you are a member of the reserves and you are called to active duty for at least 180 days, you may withdraw, on a taxable basis, a portion or all of your health care FSA balance without penalty.

Termination of Employment during the Plan Year.

Unless you elect COBRA for your current insurance benefits, (based on COBRA requirements), coverage under your insurance benefit(s) shall terminate as of the day you cease to be an employee, (exception for benefits paid a month in advance, that shall terminate following the last paid month), or when you are no longer employed by your Employer; or your contribution has been missed for any reason.

Coverage under Dependent Care Spending terminates as of the day you cease to be an employee: are no longer employed by your Employer; or your contribution has been missed for any reason. However you may submit claims for reimbursement for Eligible Employment-Related Expenses arising during the defined Plan Year; at any time until generally sixty (60) days after the end of the Plan Year, for which the election had been in effect, and to receive reimbursement. (See your Plan Information Summary for your Plans details).

If your employment with the Employer terminates during the Plan Year, your active participation in the Plan will cease and your Salary Reductions will terminate. Only expenses incurred prior to your termination (during the Plan Year) are eligible to be claimed under Unreimbursed Medical Spending Accounts, provided that you file a claim by the end of the run-out period outlined in this document. Upon termination, you will be eligible for COBRA continuation coverage only if, at the time of termination, you have a positive Unreimbursed Medical Spending Account balance, *(taking into account all reimbursement claims submitted before the date of the qualifying event).* Notification will be given if you have a qualifying event; such COBRA coverage for the Unreimbursed Medical Spending Account will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Unreimbursed Medical Spending Account because of a COBRA qualifying event (as defined in Code '4980B)f)(3)), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Unreimbursed Medical Spending Account the day before the qualifying event for the periods prescribed by COBRA (*subject to all conditions and limitations under COBRA*), with premiums for such coverage to be paid on an after-tax basis unless permitted otherwise by the Plan Administrator on a uniform and consistent basis; but not beyond the current Plan Year. Specifically, such individuals will be eligible for COBRA continuation coverage only if, they have a positive Unreimbursed Medical Spending Account balance at the time of a COBRA qualifying event (*taking into account all reimbursement claims submitted before the date of the qualifying event*). Such individual will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Unreimbursed Medical Spending Account component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Claims incurred after your coverage termination can only be reimbursed if a COBRA Continuation coverage election is both applicable and properly made.

If you terminate employment and are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than thirty (30) days after you terminate employment. If you are rehired within thirty (30) days or less, your prior election shall remain in effect for the remainder of the Plan Year.

What is a COBRA "Qualifying Event"?

Any of the following shall be considered as a "Qualifying Event":

(a). your death as a Covered Employee;
(b). termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
(c). divorce or legal separation from your spouse;
(d). your becoming eligible for benefits under Title XVII of the Social Security Act. (Medicare Benefits); or
(e). your Dependent(s) ceasing to meet the definition of a dependent.

In the case of any person treated as a Covered "Employee" but who is not a Common-Law Employee, termination of "Employment" means termination of the relationship that originally gave rise to eligibility to participate in the Unreimbursed Medical Spending Account Plan (or other group health plan subject to COBRA).

A premium for Continuation Coverage may be charged to you and/or your Qualified Beneficiaries up to one hundred-two (102%) of the premium and shall be payable at such times as are established by the Plan Administrator and permitted by applicable law.

COBRA Continuation of Coverage.

You may have the right to continue your coverage for yourself, your spouse and your dependents for certain medical benefit plans you participate in under the Plan if there is a "Qualifying Event." You (or your estate) will be eligible for COBRA continuation coverage only if, at the time of termination, you have a positive URM Account balance, (*taking into account all reimbursement claims submitted before the date of the qualifying event*). Notification will be given if you have a qualifying event; such COBRA coverage for the URM Account will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

What is a COBRA "Qualified Beneficiary"?

A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event: (a) an Employee of the Employer (including persons who are considered to be "Employees" within Code '401; (b) directors and independent contractors) covered under a health plan offered under the Plan as of such day (such persons are called "Covered Employees"); (c) the Spouse of the Covered Employee; or (d) a Dependent of the Covered Employee. An Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Employee's employment. A child born to or placed for adoption with the Employee during Continuation Coverage will be a Qualified Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary."

Each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under the URM Account Plan (or other group health plan subject to COBRA) upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage. Such extended coverage under the plan is known as "Continuation Coverage."

Who is Not a COBRA "Qualified Beneficiary"?

You are not a Qualified Beneficiary if, as of such day, you covered under the Unreimbursed Medical Spending Account Plan (or other group health plan subject to COBRA) by virtue of the election of Continuation Coverage by another person and are not already a Qualified Beneficiary by reason of a prior Qualifying Event, or

are entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, Employees who fail to elect Continuation Coverage within the election period shall not be considered to be a Qualified Beneficiary.

Automatic Termination of Continuation Coverage.

Continuation Coverage shall automatically cease if:

(a) the Employer no longer offers any group health coverage to any of its Employees;
(b) the required premium for Continuation Coverage for any coverage, is not paid within thirty (30) days of the date due or within forty-five (45) days after the initial election of Continuation Coverage made pursuant to the election period (whichever is later);
(c) an electing Qualified Beneficiary becomes covered under another group health plan other than a group health plan which may limit a Qualified Beneficiary's coverage because it involves a pre-existing condition, or
(d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare.

COBRA Notice Requirements.

(a) When an Employee becomes covered under the URM Account (*or any other group health plan subject to COBRA)*, the Plan Administrator must inform the Participant (and/or the spouse; if any), in writing of the rights to continued coverage, as described in herein;
(b) The Employer shall give the Plan Administrator, (if different from the Employer), written notice of a Qualifying Event within thirty (30) days of the occurrence thereof;
(c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Unreimbursed Medical Spending Account Plan (or any other group health plan subject to COBRA), as well as recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code '4980B and ERISA '601, in accordance with the terms of this Plan.
(d) In case of a Qualifying Event described in Qualifying Event (c) or (e) above, a Covered Employee or a Qualified Beneficiary, who is a Spouse or Dependent of such Employee, must notify the Plan Administrator within sixty (60) days of the occurrence thereof. The Plan Administrator shall give written notification of Conversion Coverage rights to any other affected Qualified Beneficiaries with fourteen (14) days of receipt of the notice.

Notification to a Qualified Beneficiary, Employee, spouse or dependent, is treated as notification to all other Qualified Beneficiaries residing with that the Employee at the time notification is made.

COBRA Election Period.

Any Employee or Qualified Beneficiary entitled to Continuation Coverage shall have sixty (60) days from the date of the notice required below, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

Effective Date of this Summary Plan Description (SPD).

This Notice is effective as of the date first written in the Plan Information Summary of this SPD, and

includes updates HIPAA Privacy Rule, initially effective April 14, 2004, and as amended for HIPAA Security Standards, April 20, 2005, (April 20, 2006 for small health plans), and as amended, by The American Recovery and Reinvestment Act of 2009 ("the Act") effective September 23, 2009, for the HIPAA Health Breach Notification Rule, and the HITECH Act, March 26, 2013. These HIPAA Privacy Rules will apply from the time the relationship begins, during the course of the relationship, as well as after the relationship ends.

Your Right to a copy of the Plan Document.

All Plan Participants shall be entitled to examine, without charge, (at the Plan Administrator's office and/or at other specified locations, such as work-sites, on-line sites and union halls); the Cafeteria Plan Documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor; such as detailed annual reports and Plan descriptions, provided the reports, do not have details of Protected Health Information and/or may obtain copies of all Plan Documents and other plan information upon written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies). Should there be found a discrepancy between the Plan Document and this Summary Plan Description or Plan Information Summary, the Employers Cafeteria Plan Document, shall be the ruling authority.

Effective January 1, 2014

HIPAA Privacy Notice for Your Cafeteria Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This policy refers to your Employer by using the term "plan", "plan administrator", "plan sponsor", "us", "we", or "our." This notice describes our Privacy Policy regarding nonpublic personal and protected health information "PHI" or Electronic Protected Health Information "EPHI" that we may collect and disclose. This information about you is protected by the Health Insurance Portability and Accountability Act of 1996, or HIPAA and is consistent with what is known as the "HIPAA Privacy Rule." Any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule. This Privacy Policy will apply from the time our relationship begins, during the course of our customer relationship, as well as after the relationship ends.

PHI, as we use in this notice, means information that identifies an individual personally and is not otherwise available to the public. It includes personal financial information such as premium amounts, flexible spending elections, employment, dependent and claim information. It also includes personal health information such as individual medical records and information about illness or injury.

OUR PRIVACY PLEDGE

We understand that information we may obtain about you and your health is personal and private. We are committed to protecting your PHI. We create a record of your health benefits and medical claims reimbursements under the Plan or for Plan administration purposes. This notice applies to all of the records we maintain. You may have different policies or notices regarding the doctor's use and disclosure of your PHI created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose PHI, about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

We are required by law to:

(a) make sure that PHI and e-PHI is kept private;
(b) give you this notice of our legal duties; privacy practices with respect to all PHI about you; and
(c) follow the terms of the notice that is currently in effect.

Plan will implement and maintain administrative, physical, technical, electronic, and procedural safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the physical and electronic PHI that the Plan creates, receives, maintains or transmits on behalf of the Plan and to comply with federal and state regulations 45 CFR Parts ' 160, 162 and 164 (HIPAA Security Standards, April 21, 2005). To ensure adequate separation, as is required by 45 CFR '164.504(f)(2)(iii) of the HIPAA Privacy Rule, is supported by reasonable and appropriate security measures; Ensure Plan sponsor shall ensure that all and any agent(s), including a subcontractor, to whom it provides EPHI, agrees to implement reasonable and appropriate security measures (i.e. firewalls) to protect such information; and report to the Plan any Security Incidents of which it becomes aware.

HIPAA PRIAVACY WITH RESPECT TO UNREIMBURSED MEDICAL SPENDING ACCOUNT PLANS

The Unreimbursed Medical Spending Account Plan (the "Plan") will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment payment for health care and health care operations, as defined in the Employer's Cafeteria Plan, and below in "How we may use and disclose PHI about you."

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU.

The following categories describe different ways that we use and disclose PHI for purposes of plan administration. For each category of uses or disclosures permitted by law, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment (as described in applicable regulations)

We may disclose PHI to a health care provider for the health care providers' treatment purposes; although it is more likely a health care provider would receive your PHI from another health care provider than from us.

Creating an Account with SABC

We provide personal information about you, as an eligible/qualifying individual meeting the requirements for enrollment or re-enrollment in the Section 125 Cafeteria Plan, as determined by your meeting the eligibility requirements' as defined by your Employer's hiring policy and IRS Section 125 regulations, to ensure all eligible employees are offered the Cafeteria Plan.

Furthermore, should you elect to participate in the optional Unreimbursed Medical Flexible Spending Account Plan, a Flexible Spending Account will be created for you, to submit eligible expenses for reimbursement under the Plan.

Payment Purposes (*as described by applicable regulations*)

We may use and disclose PHI to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. Payment includes activities undertaken to obtain premiums, to determine or fulfill its responsibility for coverage, and provision of plan benefits that relate to an individual to whom health care is provided. Likewise, we may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
- coordination of benefits, adjudication of health benefit claims (including appeals and other payment disputes);
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- medical necessity reviews or reviews of appropriateness of care or justification of charges; and
- medical reimbursements.

Claim Submission

In order to protect your PHI, SABC offers an online option for submitting your claim, via a secure site; secured with no less than 128-bit SSL encryption or higher.

WWW.SABCFLEX.COM

Should you choose to send a claim directly to any of SABC's regular email, you do so at your own PHI risk, and release SABC and your Employer from all responsibility of the risk you incur by submitting it in a non-secure electronic format. Once a claim is received however, SABC will protect the PHI, but is not responsible for what may have transpired in the transmission process.

Contacting you by telephone or by email

We may use your personal information to contact you, when necessary, to clarify and/or verify expense(s) requested by you to be reimbursed in order to comply with IRS regulations, and to expedite the processing of your claim for reimbursement payment.

Health Care Operations (as described in applicable regulations)

We may use and disclose PHI for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use PHI in connection with: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the

Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

- business management and general administrative activities, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  (b) customer service, including the provision of data analyses for participants, plan sponsors or other customers;
- resolution of internal grievances;
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity; and
- Maintain physical, technical, electronic, and procedural safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the physical and electronic PHI that it creates, receives, maintains or transmits on behalf of the individual to comply with federal and state regulations 45 CFR ' 164 (HIPAA Security Rule).

As Required By Law
We will disclose PHI when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety
Plan may use and disclose PHI when necessary to prevent a serious threat to an employee's health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To a Business Associate
Plan may disclose PHI to a Business Associate (BA), only if a valid BA Agreement is in place. A BA is an entity that performs a function for or on behalf of the Plan and uses PHI in doing so, or provides services to you or for the Plan, such as accounting, consulting or administrative services. Plan requires BA to protect the confidentiality of PHI and to use it solely for the purposes for which Plan disclosed the information, except as permitted by law. Otherwise, Plan will not disclose your protected health information.

Plan requires BA to implement administrative, physical and technical safeguards consistent with (and required by) the HIPAA Security Standards that reasonably protect the confidentiality, integrity, and availability of written or Electronic Protected Health Information (PHI) that it creates, receives, maintains or transmits on behalf of the Plan, that it is used solely for the purposes for which Plan disclosed the information, except as permitted by law, otherwise Plan does not disclose PHI. BA agrees it shall fully implement the requirements of the HIPAA Security Standards (45 CFR Parts ' '160, 162, and 164).

BA shall report to Plan any Security Incident that results in (1) unauthorized access, use, disclosure, modification, or destruction of Plan's EPHI; (2) interference with BA's system operations or information systems, of which BA becomes aware; and (3) BA shall report to Plan, upon occurrence of such non-permitted or violating use or disclosure, and the report must meet the format and content requirements imposed by the Plan. BA agrees it will insure that any agent, including subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect such information. (*Examples of BA include data programmer, storage companies, Cafeteria Plan Service Provider, enrollment agent(s) and insurance agent(s) approved and employed by the Plan*).

Your Employer.
The Plan may disclose PHI to your Employer, as the Plan Sponsor, but only if Plan Sponsor has amended its plan document as required by the Privacy Rule and certified to such, established safeguards and fire walls to limit the classes of employees who will have access to PHI and limited the use of PHI to Plan purposes and not non-permissible purposes. Except as explained below, Plan restricts access to PHI to our employees who need to know that information to provide products or services.

Therefore, Your PHI will be disclosed to certain Responsible Employees of your Employer. *These classes of employees; or Positions; or Employee Names, (defined in the Plan Information Summary; section 7. HIPAA Privacy Officer or HIPAA Security Officer), a*ny disclosure is for the purposes of administering the Plan.

These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee, who violates the rules for handling PHI established herein, will be subject to adverse disciplinary action.

The Plan may also disclose enrollment and/or disenrollment information for enrollment or disenrollment purposes only, and may disclose "summary health information" (as defined under the HIPAA medical privacy regulations), for the purpose of obtaining premium bids or modifying or terminating the Plan.

Your Employer has certified that it will comply with the privacy procedures set forth herein, and may not use or disclose your PHI other than as provided herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by your Employer for any employment-related actions or decisions, in connection with any other benefit, or employee benefit plan of your Employer. Your Employer must report to the Plan, any uses or disclosures of your PHI of which it becomes aware, that are inconsistent with the provisions set forth herein.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor
Information may be disclosed to another health plan maintained by your Employer, for purposes of facilitating claims payments under that plan. In addition, PHI may be disclosed to certain Responsible Persons or Employees (as defined in the Plan Information Summary), solely for purposes of administering benefits under the Plan.

Debit Card Affiliate
Your Plan offers a Debit Card, upon the Employee selection of the offered SABCFlex Card, the Employee also consents to the Plan sharing information with the debit card provider; "Evolution1" to obtain available balance consent, in its endeavor to pay claims. The Plan will share information with the Debit Card Affiliate, (in whole or part), to make decisions about the Employees claim for payment purposes; by obtaining the most recent card transactions or swipes and/or payments, to determine Participants Unreimbursed Medical balance availability; to fulfill Plan Sponsors adjudication responsibilities, and to provide prompt payment of claims received from the Employee.

Organ and Tissue Donation
If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risk
We may disclose PHI about you for public health activities (e.g., to prevent or control disease, injury or disability).

Health Oversight Activities
We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.

Coroners, Medical Examiners and Funeral Directors
We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and intelligence Activities
We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

If any use or disclosure of the required or permissible purposes described above are prohibited or materially limited by other applicable laws, the use or disclosure reflects the more stringent law.

Other uses and disclosures will be made only with your written authorization or that of your legal representative, and you may revoke such authorization as provided by 45 CFR ' 164.320279(b)(5) of the Privacy Rule. Any disclosures that were made when your Authorization was in effect will not be taken back.

EMPLOYEES' RIGHTS REGARDING PHI
Employees have the following rights with respect to their PHI. To submit one of the requests listed below, you must submit a written request to the Privacy Officer (as defined in the Plan Information Summary, section 7. HIPAA Privacy Officer or Privacy Security Officer).

RIGHT TO INSPECT AND COPY PHI,
As provided by 45 CFR '164.524 of the Privacy Rule, you have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to ***the Privacy Officer***. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil,

criminal or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to PHI, you may request that the denial be reviewed.

RIGHT TO REQUEST RESTRICTIONS

Employees have a right to request restrictions on certain uses and disclosures of PHI, as provided by 45 CFR ' 164.522(a) of the Privacy Rule, (although we are not required to agree to a requested restriction).

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PHI

If the employee believes our usual method of communicating PHI may endanger the employee, as provided by 45 CFR ' 164.522(b) of the Privacy Rule.

RIGHT TO AMEND PHI

You have a right to amend their PHI which you feel is incorrect. (As provided by 45 CFR ' 164.526 of the Privacy Rule). We may deny an employee's request, but will respond to the employee in either case.

To request an amendment, you must submit a written request to the Privacy Officer (as defined in the Plan Information Summary, under 7), HIPAA Privacy Officer or Privacy Security Officer).

In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, or we may deny your request if you ask us to amend information that:

- θ Is not part of the PHI kept by or for the Plan;
- θ Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- θ Is not part of the information which you would be permitted to inspect and copy; or
- θ Is accurate and complete.

The Plan must act on your request for an amendment of your PHI no later than sixty (60) days after receipt of your request. The Plan may extend the time for making a decision for no more than thirty (30) days, but must provide you with a written explanation for the delay. If the Plan denies your request, it must provide a written explanation of the denial and an explanation of your right to submit a written statement disagreeing with the denial.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES

Employees have a right to receive an accounting of disclosures we have made of employee's PHI, as provided by 45 C.F.R. '164.528 of the Privacy Rule. We are not required to, and will not, account for disclosures made for treatment, payment or health care operations, national security, law enforcement or to corrections personnel, pursuant to the employee's Authorization, or to the employee. In the written request, employees must note the time period for which they want an accounting, and the format in which they wish to receive it (e.g., paper or electronically). We will not account for disclosures made more than six years prior to the request, nor for disclosures made before HIPAA became effective [April 14, 2003]. We will provide one accounting of disclosures free of charge once every twelve months, if requested. For additional list, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. The Plan will not include in your accounting, any of the disclosures for which there is an exception under HIPAA. The Plan must act on your request for an accounting of the disclosures of your PHI no later than sixty (60) days after receipt of the request. The Plan may extend the time for providing you an accounting by no more than thirty (30) days, but it must provide you a written explanation for the delay. You may request one accounting in any twelve (12) month period free of charge. The Plan will impose a fee for each subsequent request within the twelve (12) month period.

RIGHT TO FILE A COMPLAINT

If you feel your privacy rights have been violated, (For details, see subsequent section of this Privacy Notice entitled "Privacy Complaint Procedures herein"), you may contact: the Privacy Officer (as defined in the Plan Information Summary, section 7. HIPAA Privacy Officer or Privacy Security Officer).

RIGHT TO A PAPER COPY OF THIS NOTICE

Employees have the right to a paper copy of this Privacy Notice. Employees will be provided the option for a paper copy of the Plan's Privacy Notice at the point of signing the Plan's Section 125 Cafeteria Plan Election and Salary Reduction Agreement. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice when requested.

To obtain a paper copy of this notice, you may contact the Privacy Officer (as defined in the Plan Information Summary, section 7. HIPAA Privacy Officer or Privacy Security Officer).

The Plan satisfies its distribution obligation by furnishing the Privacy Notice to the "Employee", as listed on the Section 125 Cafeteria Plan Election and Salary Reduction Agreement that is, the subscriber for coverage, and also applies to their spouses and any dependents.

ADDITIONAL OPTIONS TO RECEIVE YOUR PRIVACY NOTICE

Employees may prefer to receive their copy in an electronic format; made available at your Employer's website, as defined in the Plan Information Summary, in or by email at the last email address provided on your Election and Salary Reduction Agreement. If you provided your email on the Plan's Election and Salary Reduction Agreement, you have agreed to receive any material modification and/or every three (3) year update at the last email address provided on the Election and Salary

Reduction Agreement, and by posting the Privacy Notice on the designated delivery site in a clear and prominent place where Employees seeking the information may reasonably be expected to be able to read the notice. You are also able to view our service providers' SABC's Privacy Notice at their website www.sabcflex.com.

PRIVACY COMPLAINT PROCEDURES

The Plan must make its internal practices, books and records related to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with these privacy protections.

When your Employer no longer needs PHI for the Plan, (for the purposes for which the PHI was disclosed), Your Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Your Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

If you believe your privacy rights have been violated; you may file a complaint with the Plan's Privacy Officer.

All complaints must be submitted in writing, either on paper or electronically, by mail, fax, or email to ***the Privacy Officer.***

To file a complaint with the Plan you may contact: the Privacy Officer (as defined in the Plan Information Summary, section 7. HIPAA Privacy Officer or Privacy Security Officer).

The complaint must include the covered entity involved and describe the act or omissions you believe violated the Privacy or Security Rule, and be filed within one hundred-eighty (180) days of when you knew that the act or omission complained of occurred.

You may also file a complaint with the U.S. Department of Health Services; "HHS" if you feel your privacy rights has been violated. You can obtain a copy of the complaint form from the Privacy Officer or you may obtain a copy of the form from the Office of Civil Rights at the U.S. Department of health and Human Services over the internet at:

http://www.hhs.gov/ocr/hipaa

Complaints may be filed with HHS by email to: OCRMail@hhs.gov. Alternatively, you can file the complaint by mail or fax at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
233 North Michigan Avenue, Suite 240
Chicago, Illinois 606662
(312) 886-2359
Fax: (312) 886-1807

All complaints should identify the Plan and list the acts or omissions that you believe violate your privacy rights. The complaint must be filed with the HHS at the above options, within one hundred eighty (180) days of the date you knew or should have known of the alleged violation. The government may waive the one hundred eighty (180) day filing deadline if you can show good cause why you failed to file the complaint in time.

The Plan and your Employer may not, and will not, penalize or retaliate against anyone for filing a complaint with the Privacy Officer and/or HHS. In addition, the Plan and/or your Employer will never ask you to waive your rights under HIPAA.

PLAN SPONSORS "EMPLOYER" OBLIGATION AND RESPONSIBILITY

Where Electronic Protected Health Information ("PHI") will be created, received, maintained, or transmitted to, or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic PHI as follows:

A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of all PHI and EPHI that the Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan, and to ensure technical policies and procedures are in place for EPHI;
B. Plan sponsor shall ensure that the adequate separation that is required by 45 CFR ' 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement hardware, software, and or procedural mechanisms, reasonable and appropriate security measures to protect such information;
D. Implement Audit Controls that record and examine access and other activity in information systems that contain or use EPHI.
E. Implement policy and procedures for integrity controls to ensure that EPHI is not improperly altered or destroyed.
F. Implement technical security measures that guard against unauthorized access to EPHI being transmitted over an electronic network.
G. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    1. Plan sponsor shall report to the Plan, within a reasonable time after Plan sponsor becomes aware; any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and
    2. Plan sponsor shall report to the Plan any other Security Incident as it occurs or upon the Plan's request.

We are required by law to maintain the privacy of employee PHI. We are obligated to provide the employee with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI and we must abide by the terms of this notice. We reserve the right to change the provisions of this Notice and make the new provisions effective for all PHI that we maintain. If we revise this notice, we will notify employees of these changes by mailing the revised notice to affected employees at the last known address, or electronically to the last consented and provided email address.

Comply with the Genetic Information Nondiscrimination Act of 2008 ("GINA") that prohibits discrimination by group health plans and employers against an individual based on the individual's genetic information, and requires that such information be treated as PHI. The term "genetic information" includes information about an individual and/or their family members genetic tests, (including first through fourth-degree relatives), and the manifestation of a disease or disorder in a family member (including any request for a receipt of genetic services or participation by the individual or family member in clinical research that includes genetic services).

PROTECTED HEALTH INFORMATION BREACH AND NOTIFICATION REQUIREMENTS

The American Recovery and Reinvestment Act of 2009, effective September 23, 2009, ("the Act") requires notice to affected individuals of any *breach* of *unsecured* protected health information. Covered entities are to comply with the Act.

Summary of "the Act"

Requirements apply if all of the following are present:

- **There is a "breach."** The Rule defines "breach" to mean (subject to exceptions discussed below) the unauthorized acquisition, access, use, or disclosure of protected health information ("PHI").

- **The PHI is "unsecured."** The Rule defines "unsecured protected health information" to mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by HHS guidance.

- **The breach "compromises the security of the PHI."** Under the Rule, this occurs when there is a significant risk of financial, reputation, or other harm to the individual who's PHI has been compromised.

What is Secured PHI?

PHI is considered Secured PHI, when technologies and methodologies that renders the PHI unusable, unreadable, indecipherable or de-identified to unauthorized individuals are in place. PHI is rendered unusable, unreasonable, or indecipherable to unauthorized individuals only if one or more of the following methods are used:

(1) *Encryption*. Electronic PHI or e-PHI is secured where it has been encrypted. Encryption means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key. Our encryption processes meets the standard requirements of 128 bit SSL encryption. Further, such confidential process or key, that enable decryption are kept in a separate location and only eligible recipients of transmitted data are able to receive the confidential indecipherable or de-identified data, in accordance with 45 CFR 164.514(b), and by use of password protection by HIPAA approved recipient; and

(2) *Destruction*. Hard copy PHI, such as paper or film media, is only secured where it has been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. All Hard copy PHI in paper format, which is received by mail, fax, written or created as a result of processing the paper PHI, is destroyed by the shredding of all paper copies.

Plan Sponsor, covered entities and BA will analyze the following in determining whether a breach to the Plan of unsecured PHI has occurred by:

(1) Determine whether the use or disclosure of PHI violates the HIPAA Privacy Rule. For an acquisition, access, use, or disclosure of PHI to constitute a breach, it must constitute a violation of the HIPAA Privacy Rule. For example, if information is de-identified in accordance with 45 CFR 164.514(b), it is not PHI and any inadvertent or unauthorized use or disclosure of such information, will not be considered a breach under the notification requirements of the Act and the Rule.

(2) Analyze whether there is a use or disclosure that compromises the security and privacy of PHI. Use or disclosure that "compromises the security and privacy of PHI" means a use or disclosure that "poses a significant risk of financial, reputation or other harm to the individual." Thus, in order to determine whether a breach has occurred, Plan Sponsor, covered entities and business associates will conduct a risk assessment to determine whether the potential breach presents a significant risk of harm to individuals as a result of an impermissible use or disclosure of PHI.

(3) Assess Whether any Exceptions to the Breach Definition Apply. The following three situations are excluded from the definition of "breach" under the Act:

(i) The unintentional acquisition, access, or use of PHI by any workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by the Privacy Rule.

(ii) The inadvertent disclosure of PHI by an individual otherwise authorized to access PHI at a facility operated by a covered entity or business associate to another person at the same covered entity or business associate, or at a organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

(iii) An unauthorized disclosure where a covered entity or business associate has a good faith belief that an unauthorized person to whom PHI is disclosed would not reasonably have been able to retain the information.

Plan Sponsor, covered entity or business associate has the burden of proving why a breach notification was not required and must document why the impermissible use or disclosure fell under one of the exceptions, and shall document the risk and other breach assessments accordingly.

Plan Requirements for Breach Notification:

Individuals will receive a Notice of breach of PHI, triggered upon the "occurrence" or "discovery" of a qualifying breach of unsecured PHI. A breach is treated as "discovered" by the Plan Sponsor, covered entity or business associate as of the first day the breach is known, or reasonably should have been known, to the Plan Sponsor, covered entity and/or business associate. Plan Sponsor, covered entity or business associate shall implement reasonable breach discovery procedures required by:

- **Notification to Individuals.** Plan Sponsor, covered entity, or business associate shall send the required notification to each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the breach, without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was first discovered by the covered entity.

  Plan Sponsor, covered entities and/ or business associates will provide a substitute notice, as soon as reasonably possible. If entity does not have sufficient contact information on the breach individuals for ten (10) or more individuals, then substitute notice will be provided via a posting for a period of ninety (90) days on the home web page of its web site or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. In such instances, an active toll-free number will be provided for ninety (90) days so that an individual can find out whether his or her unsecured PHI may be included in the breach.

- **Notification to Media.** If a breach is discovered affecting more than five hundred (500) residents of a state or jurisdiction, notice will be provided to prominent media outlets serving the state or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered by the covered entity.

- **Notification to HHS.** If more than five hundred (500) individuals are involved in the breach, regardless of whether the breach involved more than five hundred (500) residents of a particular State or jurisdiction, then HHS will be notified concurrently with the individual notifications. For breaches involving fewer than five hundred (500) individuals, an internal log or other documentation of such breaches will be maintained and will be annually submitted to HHS.

- **Notification by a Business Associate.** Following the discovery of a breach of unsecured PHI by a business associate, the business associate is required to notify the covered entity and/or Plan Sponsor of the breach and Plan Sponsor and/or covered entity can, in turn, notify the affected individuals. To the extent possible, business associate shall identity each individual whose unsecured PHI has been, or is reasonably believed to have been, breached. Such notice shall be given without unreasonable delay and no later than sixty (60) days following discovery of a breach.

- **Delay Required by Law Enforcement.** The Act provides that a breach notification may be delayed if a law enforcement official determines that such notification would impede a criminal investigation or cause damage to national security.

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice, or the laws that apply to us, will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change this Privacy Notice. We reserve the right to make the revised and/or changes to this notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of this current notice on the Plan/Employer's website, or Email a copy to the Employees that have agreed to receive any material modification or every three (3) year update, at the last email address provided by your or your Employer. The notice will contain, on the first page, in the top right-hand corner, the effective date of this Privacy Notice.