

# **COUNTY OF VOLUSIA**

## **Vision Plan**

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### **Summary Plan Description**

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**Effective: January 1, 2011**

**Group No. 2081**

## **INTRODUCTION**

Benefits described in this booklet are effective January 1, 2011. Your Group Number is 2081.

This manual has been prepared by the County of Volusia to assist you and other members covered under this group Vision Plan in understanding your Employee Vision Benefits. It describes all the information you need to know about your vision coverage, using a simplified format. It is divided into sections including enrollment, claims filing, benefit coverage, benefit limitations, definitions, and governmental protections. Some of the words used in this booklet begin with a capital letter. These words are defined in the Definitions section. When reading this booklet, it may be helpful to refer to this section.

All the benefits of your Vision Plan are fully explained in this manual. It should be noted that any claims are to be filed with FSAI.

If you receive any information on this Plan and it is contradictory or silent in describing this Plan, this Summary Plan Description will prevail and is the governing document for this Plan.

This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

Section headings, sub-headings, heading size or typeface are used for convenience of reference only and will not affect the validity, construction or effect of the Plan provisions, and are not meant to convey or imply that any greater or lesser benefits are payable than are covered under the Plan.

**PLEASE READ THIS DOCUMENT CAREFULLY.**

## PATIENT PROTECTION AND AFFORDABLE CARE ACT

The County of Volusia believes the Health Partnership Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Health Partnership Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

County of Volusia  
Personnel Division – Benefits Section  
230 N. Woodland Blvd., Ste. 262  
DeLand, FL 32720

386 736-5951 - DeLand

[For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]

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# ELIGIBILITY

## Eligible Participants

All persons in a regularly established position with the County of Volusia classified as full-time or permanent part-time, who are scheduled to work 17-1/2 or more hours per week or on an approved Leave of Absence are eligible to be covered under this Plan after 31-days of employment.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

All eligible Employees who retire while covered by This Plan, and are eligible to receive benefits from the Florida State Retirement System, are eligible for Coverage.

Contracted employees and elected officials as approved by the HPP Administrator are also eligible for Coverage.

An Employee or Dependent cannot be covered if he/she is maintaining a residence outside the Continental U.S.

An Employee cannot be covered as both an Employee and as a Dependent under this Plan.

## Eligible Dependents

Your Eligible Dependents, as defined in the Definition section of this Plan, are eligible for Coverage under this Plan. A newborn child of a covered Dependent child is eligible to participate from birth up to age 18-months.

Your Eligible Dependents, as defined below are eligible for Coverage under this Plan. A newborn child of a covered Dependent child is eligible to participate from birth up to age 18-months.

**Dependent** means the Covered Employee's spouse and children.

The term "**spouse**" means the legally recognized marital partner, excluding the domestic partner, of a Covered Employee. The term shall exclude such spouse who has divorced the Employee, or who is legally separated from the Employee.

The term "**children**" means natural children, step-children, foster children, or children who have been placed under legal guardianship and legally adopted children from birth to age 26 (whether married or unmarried). This applies to any children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

The Plan may choose to not extend coverage for adult children who are eligible for coverage under another employer-sponsored group health plan (other than another parent's plan), but only for plan years beginning before January 1, 2014. This does not apply to stand alone dental and vision plans but Employer may voluntarily extend dependent coverage to adult children in such plans.

Note: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Health Partnership Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Personnel Division at 386-736-5951.

## ELIGIBILITY (Continued)

The term "**children**" also means pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, irrespective of whether the adoption has become final, and with no pre-existing conditions limitations applied provided the Dependent is under age 19 and is enrolled in a timely manner as stated within.

The term "**children**" also means a Covered Member's child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under This Plan as an "alternate recipient." The HPP Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609, and within a reasonable time after receiving an order will determine whether or not the order is qualified, and whether or not the child has been determined to be an "alternate recipient." The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

A child determined to be an "**alternate recipient**" will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, with no pre-existing conditions limitations applied provided the Dependent is under age 19 and is enrolled in a timely manner as stated within.

All children are eligible for Coverage until the end of the calendar year in which the child reaches the age of 26. However a child will remain a Dependent until the end of the calendar year in which the child reaches the age of 30, even after leaving college and home, so long as the young adult meets the following conditions:

- Must either live in Florida or be a full-time or part-time student whose parent resides in Florida;
- Must not be married;
- Must not have a dependent of his or her own;
- Must not be covered by another health plan or policy (group or individual) or by Medicare; and
- If the child was covered under the parent's health insurance policy up to the age of 26, and that coverage was subsequently terminated, the child must have been continuously covered by other health insurance without a gap in coverage of more than 63 days in order to re-enroll in the parent's health insurance policy.

Dependent children from age 27 to 30 will incur additional cost for the coverage, see your Benefits Department for details.

If the employee fails to notify the HPP Administrator, in writing within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

**Special Exception for Medical Necessity (Michelle's Law):** Notwithstanding the foregoing a covered Employee's unmarried child will not immediately lose eligibility to participate in the Plan if such child loses his or her required student status as a result of a change in enrollment (included a leave of absence) that (i) is medically necessary and (ii) commences while the child is suffering from a serious illness or injury. This special exception for medical necessity will delay termination of coverage until the earlier of one year from the first day of the medically necessary leave of absence or the date that the Dependent would otherwise lose coverage under the Plan for reasons other than student status (e.g. age limitations), unless the child regains full-time student status prior to such termination date.

The term **Dependent** also includes an Employee's unmarried child while the child is Physically, or Mentally Handicapped and is incapable of earning his own living, and who is actually dependent on

## ELIGIBILITY (Continued)

either parent for a majority of his maintenance and support, and who is a Covered Member on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the HPP Administrator within 31-days of the date his health Coverage would have terminated due to age.

In the event both parents of an eligible Dependent child are Covered Members, then for the purposes of this Coverage, such child is considered as a Dependent of either parent, but not both parents.

No eligible person can be a Covered Employee, and a Covered Dependent at the same time. No person can be covered as a Dependent of more than one Employee.

Your Eligible Dependents are eligible for Coverage on the date you become eligible for Coverage or on the date you first acquire a Dependent. There are, however, special rules that apply to newborn children and adopted children. Refer to those specific provisions for further information.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

### Requirements

Coverage will not become effective unless a properly completed and signed enrollment application is submitted. No Coverage will be placed in effect unless the required payroll deductions, if any, are paid to the Plan. As explained under "IRS SECTION 125 - FLEXIBLE BENEFIT PLANS," your employer will deduct your contributions before taxes are calculated and deducted from your paycheck.

**You must enroll within the first 14-days of your employment date, or if an IAFF bargaining union Employee on or before the 31<sup>st</sup> day of employment.** If you desire Dependent Coverage, you must also enroll your eligible Dependents at that time. Dependents you acquire after this time must be enrolled within 31-days of the date you acquire them.

As a requirement for enrollment in the Plan, all Eligible Dependents of Covered Employees will be required to provide their social security number to the Plan Administrator. This is necessary to allow the Plan Administrator to comply with any and all reporting requirements imposed under federal CMS guidelines.

### Genetic Information Nondiscrimination Act ("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.

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.

## **ELIGIBILITY (Continued)**

“Family members” include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption.

“Underwriting” includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. 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.

# IRS SECTION 125 - FLEXIBLE BENEFIT PLANS

Federal tax law, Section 125 of the Internal Revenue Code, authorizes the establishment of Flexible Benefit Plans, sometimes called FlexPlans. These FlexPlans are set up by employers to assist their Employees in saving money by allowing Employees to pay for certain expenses with pre-tax dollars. This means they are not subject to withholding for federal income tax, social security tax and the income tax of most states.

The Pre-Tax Premium Plan allows Employees to pay for their group vision benefit coverage with pre-tax dollars by authorizing their employers to take payroll deductions for the cost of the coverage before taxes are calculated and deducted from the Employee's paycheck.

Participation in the FlexPlan lowers taxes by reducing the amount of taxable income. How much taxes are lowered depends on many things: total taxable income, whether or not an individual or joint return is filed, federal and state tax rates, whether or not deductions are itemized or the standard deduction is taken, the number of exemptions and so forth.

Social Security benefits may be affected for those whose earnings are below the Social Security Taxable Wage Base. Otherwise, there should be no unfavorable consequences to participating in a Flexible Benefit Plan.

Section 125 of the Internal Revenue Code which allows these special tax breaks also imposes the strict requirement that the choices an Employee makes must stay in effect for a full plan year, or through the end of the plan year in which the Employee becomes a participant.

Employees cannot add, drop, or change coverage except during the Annual Choice Period or within 31-days of a Change in Status as described below.



The County of Volusia has established a Pre-Tax Premium Plan and your premium expenses (for yourself and all enrolled eligible Dependents) for medical will be paid with pre-tax dollars.

You are not required to participate in the County of Volusia Health Partnership Plan, but if you do enroll for coverage, participation in the Pre-Tax Premium Plan is mandatory and automatic. Your premium expenses will be deducted from your paycheck before any taxes are calculated and deducted.

If you do not want to participate in the Pre-Tax Premium Plan you must sign a Refusal of Coverage, declining any coverage offered under the Plan and provide proof of other vision insurance coverage.

Once you elect to participate in the Pre-Tax Premium Plan, you cannot add, drop or change your coverage until the next Annual Choice Period, which will be the month of November each year, unless there is a Change in Status as described below. In the case of a Change in Status, you have 31-days from the date of the event to make any changes.

## IRS SECTION 125 - FLEXIBLE BENEFIT PLANS (Continued)

**Make your decision carefully. You will not be able to change your coverage, or stop your contributions during the year unless one of the following changes in status occurs:**

1. The marriage, divorce, or legal separation (where legally recognized) of an Employee;
2. The death of the Employee's Spouse, or a Dependent;
3. The birth, or adoption of a child of the Employee;
4. The termination, or commencement of employment of Employee's Spouse;
5. The switching from part-time to full-time employment status, or from full-time to part-time status by the Employee, or the Employee's Spouse;
6. The taking of an unpaid Leave of Absence by the Employee, or Employee's Spouse;
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment; or
8. The loss of coverage related to Medicaid or SCHIP (see pages 8-9 ).

## **ENROLLMENT & ENROLLMENT DATES**

### **New IAFF Employees and Dependents Enrolled in a Timely Manner**

An IAFF bargaining union Employee may enroll in the HPP for Employee and Dependent coverage on, or before the 31st day following his employment date. Employee Coverage begins on the first day of the fifth (5th) pay period following the date of employment.

The County of Volusia reserves the right to waive the ten (10) week waiting period for contracted employees and elected officials.

### **All Other New Employees and Dependents Enrolled in a Timely Manner**

An Employee may enroll in the HPP for Employee and Dependent coverage on, or before the 14<sup>th</sup> day following his employment date. Employee and Dependent Coverage begin on the first day of Employee's employment. This change does not apply to any employees represented by the IAFF bargaining union.

### **New Employees NOT Enrolled in a Timely Manner**

If an Employee does not enroll in the HPP in a timely manner or refuses coverage at the time of enrollment, and does not provide proof of other health care coverage to the HPP Administrator, then the Employee will be automatically enrolled in single coverage by the HPP Administrator. (The premium for this coverage is paid for by the employer.)

### **Enrolling Newly Acquired Dependents**

If an Employee does not have an Eligible Dependent when his Coverage first becomes effective and then later acquires an Eligible Dependent for the first time (other than through the birth, or adoption of a child), the Employee may apply for Dependent coverage within 31-days from the date the Eligible Dependent was first acquired. Coverage will begin on the first day of the pay period following the date the application for Coverage was made..

## **CHANGE IN STATUS**

If, as a result of a Change in Status, an Employee has the right to add additional Coverage, then the Employee will have 31-days after the date of the event that constituted the Change in Status to notify the Plan of his or her new election. If an Employee fails to notify the Plan within this 31 day period, he would not be eligible to apply for the additional Coverage until the next Annual Enrollment Period.

If, as a result of a change in status, an Employee has the right to reduce Coverage (or if Coverage is automatically reduced under the group health care Plan), the Employee will have 31-days after the date of the Change in Status to notify the Plan of his election to reduce Coverage. If the Employee notifies the Plan within this 31 day period, the change of Coverage will apply the last day of the pay period in which your Status Change is approved, as defined in the Flexible Benefits Plan. (Please see the COBRA section of this book for information regarding the continuation of coverage for members that no longer have coverage.)

## SPECIAL ENROLLMENT RULES

If you do not enroll in the HPP within the first 14-days of employment, or if an IAFF bargaining union Employee on or before the 31<sup>st</sup> day of employment, you may not enroll in the HPP until the next Annual Enrollment Period and you will be subject to a Pre-Existing Condition limitation of up to 18-months from your Enrollment Date (as described under "Pre-Existing Condition Limitation"). However, if you decline enrollment in the HPP for yourself, or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible for "special enrollment", which would allow you to enroll yourself, or your Dependents in the HPP, but only if both:

1. At the time you decline Coverage, you give a written statement to FSAI, that the reason you, and/or your Dependents are declining enrollment is because of coverage under another group health plan, or other health coverage; and
2. You request enrollment within 31-days after the other coverage ends.

If you meet these requirements, your Coverage will be effective retroactive to the date the other coverage ends and an up to 12-month pre-existing condition limitation will apply.

If you are not eligible for this special enrollment, and if you are not eligible to enroll because of a change in status, you may not enroll in the HPP until the next open enrollment period as described above.

To verify your eligibility for this special enrollment, the HPP Administrator may request and obtain information, such as the reasons your prior coverage terminated. Acceptable reasons are termination of an employer's contribution towards the other coverage or loss of eligibility for the other coverage, for example, due to legal separation, divorce, death, termination of employment, reduction in the number of hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Reasons that are not acceptable are failure to pay premiums on a timely basis or termination of other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the HPP).

In addition, if you have a new Dependent or Dependents as a result of marriage and you are otherwise eligible for coverage under the HPP, you may enroll yourself and your new Dependent(s) provided that you request enrollment within 31-days after the marriage. If timely application is made, coverage will be effective retroactive to the date of the marriage.

If you have a new Dependent as a result of birth, adoption, or placement for adoption, and you are otherwise eligible to be enrolled in the HPP, you may enroll your new Dependent, yourself, and your spouse, provided that you request enrollment within 31-days after the birth, adoption, or placement for adoption. If timely application is made, coverage will be effective as of the date of the birth, adoption, or placement for adoption.

**Special Enrollment Related to Medicaid and SCHIP.** You or your Dependent may be eligible for Special Enrollment in the HPP if you or your Dependent:

1. lose coverage under a Medicaid or a State Children's Health Insurance Program under titles XIX and XXI of the Social Security Act (referred to, respectively, as "Medicaid Plan" and "State Plan"); or
2. become eligible for group health plan premium assistance under a Medicaid Plan or State Plan; and

3. you request enrollment in the HPP within 60 days after the coverage under the Medicaid or State Plan ends you or your Dependent become eligible for Premium assistance under a Medicaid or State Plan.

If you meet these requirements, your Coverage will be effective on the first day of the month following receipt of the fully completed enrollment form and a Pre-Existing Condition Limitation of up to 12 months may apply.

To verify your eligibility for this Special Enrollment, the HPP Administrator may request and obtain additional information.

## **CHANGES IN COVERAGE**

Changes in Coverage will be effective on the first day of the pay period in which the change occurred. Any changes involving increased Coverage will be subject to the applicable provisions of the Eligibility and Enrollment Dates requirements, and the rules and regulations regarding IRS Section 125 - Flexible Benefits Plans.

# TERMINATION OF COVERAGE

## **Employee Termination**

The Coverage of an Employee covered under this Plan shall terminate on the earliest of the date:

1. the last day of the pay period in which they terminate employment, or
2. the Group Plan Coverage terminates, or
3. the last day premiums are paid, or
4. the Employee is no longer considered to be an Employee eligible for Coverage, or
5. COBRA Continuation Coverage terminates, if the Employee had elected such Continuation Coverage.
6. Continuation Coverage as set forth in the Uniformed Services Employment and Reemployment Rights Act terminates, if the Employee who was on duty in the Uniformed Services for more than 31-days, had elected such Continuation Coverage.

If a Covered Employee is terminated for cause (fraud or intentional material misrepresentation), Coverage may end on the date of termination. Contact Personnel Services for details if you are on Disability, Leave of Absence, or away from work for other reasons.

## **Dependent Termination**

The Coverage of any Dependent covered under This Plan shall terminate on the earliest of the date:

1. the Employee's Coverage terminates, or
2. the Group Plan Coverage terminates, or
3. the last day Dependent premiums are paid, or
4. a Dependent no longer qualifies as an eligible Dependent as defined by the Plan, or
5. the Dependent becomes a Full-Time member of the Armed Forces of any Country, or
6. COBRA Continuation Coverage terminates, if the Dependent had elected such Continuation Coverage.
7. Continuation Coverage as set forth in the Uniformed Services Employment and Reemployment Rights Act terminates, if the Dependent of an Employee who was on duty in the Uniformed Services for more than 31-days, elected such Continuation Coverage.

## LEAVES OF ABSENCE

### ❖ **Approved Full Or Partial Paid Leave**

Coverage paid by the County continues during the approved paid Leave of Absence. Dependent and Employee premiums continue to be deducted.

### ❖ **Family Medical Leave Act**

Approved Unpaid Leave of Absence for 12-weeks or less. Coverage paid by the County continues as if an active Employee. Dependent premiums and Employee Co-Payments are paid directly to Personnel Services.

### ❖ **Approved Unpaid Leave of Absence**

Coverage paid by the County terminates, and Employee is eligible to elect COBRA Continuation of Coverage with the Employee paying premiums at the applicable rate.

### ❖ **Retirement (Florida Retirement System)**

Coverage may be continued indefinitely, subject to timely premium payments. To qualify, normal retirement date is age 62 with six years of vested service or 30 years of service at any age (age 55 with six years of service or 25 years of service for Special Risk).

Dependent coverage for the covered Dependent spouse of a Retiree will not terminate upon the death of the Retiree but shall continue indefinitely, subject to timely premium payments.

## National Defense Authorization Act (NDAA)

Regardless of an Employer's established Leave of Absence policy, the Plan will at all times comply with the following regulations:

The **National Defense Authorization Act** (NDAA) which expands Family Medical Leave (FMLA) to include employees caring for an injured service member as well as family members who have a family member called to active duty. The Act permits a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness." This Act also permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation."

Additional information concerning the NDAA can be obtained from your Human Resources Department.

## **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

Regardless of the Employer's established Leave of Absence policies, This Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act for Covered Employees going into or returning from military service. These rights include up to 24-months of extended vision care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate Coverage in This Plan upon return from service.

Plan exclusions and waiting periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

For additional information concerning the USERRA, including your rights and responsibilities under the Act, please contact Personnel Services.

## GENERAL PLAN PROVISIONS

All benefits provided under This Plan are subject to the following basic terms and conditions. A thorough reading and understanding of these terms and conditions will help you maximize your Plan benefits.

### **Benefit Maximums**

Total Plan payments for each Covered Member are limited to certain Benefit Maximums. A Benefit Maximum can apply to a specific benefit or to all benefits. A Benefit Maximum can be a specific dollar limit; a specific limit on services, such as number of visits or days; a specific time period or any other specific limit imposed upon a benefit, or benefits, by This Plan.

The Benefit Maximums that apply are shown in the individual Schedule of Benefits of This Plan.

## VISION EXPENSE BENEFITS SCHEDULE OF VISION EXPENSE BENEFITS

Deductible Amount ..... None

<u>Vision Expense Benefits</u>	<u>Amount of Benefits and Limitations</u>
• Eye Examinations .....	100%, up to \$50. Limited to one (1) examination per person per calendar year.
• Frames .....	100%, up to \$100. Limited to one (1) pair of frames per person during any 24 consecutive months.
• Lenses:	
❖ <i>Single Vision Lenses</i> .....	100%, up to \$25 per pair. Limited to one (1) pair per person per calendar year.
❖ <i>Bifocal Vision Lenses</i> .....	100%, up to \$25 per pair. Limited to one (1) pair per person per calendar year.
❖ <i>Trifocal Vision Lenses</i> .....	100%, up to \$32.50 per pair. Limited to one (1) pair per person per calendar year.
❖ <i>Contact Lenses</i> .....	100%, up to \$100 per person per calendar year
❖ <i>Progressive Lenses</i> .....	100%, up to \$32.50 per pair. Limited to one (1) pair per person per calendar year.

**FOR DETAILS, REFER TO THE PLAN PROVISIONS CONTAINED IN THIS SECTION.**

## **VISION EXPENSE BENEFITS**

All Vision Expense Benefits must be performed, ordered, furnished or prescribed by an Ophthalmologist, an Optometrist or Optician acting within the scope of his license. All covered charges must be based on Usual, Reasonable and Customary fees for the services and supplies listed under Vision Expense Benefits. Services must be rendered and supplies furnished while the individual is covered under the Plan.

Payment for Covered Vision Expense Benefits will be made at the Co-Payment Percentages shown in the Schedule of Vision Expense Benefits, subject to the Limitations, the Benefit Maximums, the Definitions and all other provisions of the Plan.

Payment for any one service or supply will not exceed the lesser of the fee actually charged or the maximum amount payable for such services as indicated in the Schedule of Vision Expense Benefits.

A charge is considered to be incurred on the date the service is performed or the supply is ordered.

## **COVERED VISION EXPENSE BENEFITS**

The Plan will pay expenses incurred for the following visual care services and supplies:

1. Examinations, including refractions, performed by a licensed ophthalmologist or optometrist.

An eye examination includes your complete case history, a comprehensive analysis of your visual functions, the prescription of lenses where indicated and the verification and fitting of such lenses if prescribed.

2. Lenses, including contact lenses, prescribed by an ophthalmologist or optometrist in connection with a failure in visual acuity.

Expenses for lenses will be payable only if the lenses are prescribed as a result of an eye examination made while you are covered for these Vision Expense Benefits. The date on which the lenses are ordered will be considered the date on which the charge is incurred.

3. Frames purchased in conjunction with lenses newly prescribed by an ophthalmologist or optometrist. The date on which the frame is ordered will be considered the date on which the charge is incurred.

## VISION EXPENSE EXCLUSIONS & LIMITATIONS

**In addition to the General Plan Exclusions and Limitations, this Plan will not pay for:**

1. for procedures, services or supplies that are not specifically included as Covered Vision Expenses;
2. for services and supplies in connection with special procedures such as, but not limited to, orthoptics, vision training, subnormal vision aides, or aniseikonia lenses, coated lenses or any other special purpose vision aids;
3. for or in connection with medical or surgical treatment of the eye, including Radial Keratotomy or other refractive Surgery or for any prescribed drug or other medication;
4. for services or supplies which were furnished or rendered or for which charges were incurred prior to the effective date of coverage under these Vision Expense Benefits or after such Vision Expense Benefits terminate;
5. for frames to be used with lenses which do not require a prescription;
6. for any procedure, service or supply which is payable under any medical expense benefit plan provided by your Employer or provided through a medical department or clinic maintained by your Employer;
7. for services or supplies rendered or furnished primarily for cosmetic purposes; and
8. services or supplies received or rendered by a member of the immediate family of the Employee or the Employee's spouse.
9. for the purchase of contact lenses in addition to eye glasses within the same Plan Year

## HOW TO FILE A CLAIM

1. Complete the "Employee" portion of the claim form.
2. If payment is to be made directly to the provider, sign the "Authorization To Pay Provider" statement.
3. Have the patient or parent sign the "Authorization To Release Information" statement.
4. For the initial claim, attach the provider's itemized bill to the completed claim form. The itemized bill must include:
  - \*Name and Social Security Number of the Employee
  - \*Name of the Patient
  - \*Name and Address of the Provider
  - \*Type of Services Rendered
  - \*Diagnosis
  - \*Date of Services
  - \*Charges
5. If the Employee does not have the actual itemized bill, have the Physician complete their respective section on the back of the claim form.
6. If claims are being made for several family members, complete a separate claim form for each individual.
7. Mail completed claim forms and itemized bills to:

**FSAI**  
**780 W. Granada Blvd., Ste 250**  
**Ormond Beach, FL 32174**

**Only one claim form per year** for Vision needs to be completed for any Covered Member requesting benefit payments. The provider's itemized bill will be sufficient for any additional claims requests, providing it contains the information listed in the employee section of the claim form.

All claims should be filed immediately, but **must be filed within 12-months** of the date charges for the service were incurred.

### **Explanation of Benefits**

The Explanation of Benefits explains what expenses This Plan will pay for, and what expenses you must pay for. You will receive an Explanation of Benefits for every claim processed.

## HOW TO APPEAL A DENIAL OF BENEFITS

If you believe a claim was improperly settled, in whole or in part, you have the right to appeal the claim settlement by making a written request for review to FSAI, the Claims Administrator, within 180 days of notification.

You have the right to review this Summary Plan Description and other papers affecting the claim. You also have the right to have a representative act on your behalf in the appeal.

The Plan will review the processed claim and inform you in writing as to their decision within:

- ◆ 72 hours for urgent claims;
- ◆ 30 days for pre-service claims;
- ◆ 60 days for post-service claims;

of the receipt of the request for review. In the event a claim is denied the Covered Person will be advised of the reason for the denial with specific reference to The Plan provision(s) on which the denial was based and any additional material or information needed for further review of the claim.

If you are not satisfied with the first review, a written request for a second review may be submitted. You must submit your request for a second review keeping within the 180 days of the initial notification. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed.

When the written request is received, the claim will be reviewed again and the results of this review furnished to you in writing keeping within the same timeframes, as stated above, that applied to the initial review of the claim.

If you are not satisfied with that determination and wish to pursue your appeal, you must complete an Authorization Form found in the back of the Summary Plan Description or on the County ENN page, before you can request assistance from the Plan Administrator, Personnel Division Benefits Section.

# GENERAL CLAIM PROVISIONS

## **Time Limit for Submitting Claims**

All claims should be submitted as soon as possible after the charges are incurred. In any event, all claims must be submitted within one- (1) year of the date charges are incurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered, or supplies are actually received.

## **Time Payment of Claims**

Claims for all benefits due under This Plan will be processed promptly after a proper written claim form has been received.

## **Assignment of Benefits**

Under normal conditions, benefits are payable to you, and can only be paid directly to another party upon signed authorization from you. All benefits payable by This Plan may be assigned to the provider of services, or supplies at your option. Payments made in accordance with an assignment are made in good faith and discharge the Plan's obligation to the extent of the payment.

If conditions exist under which a valid release, or assignment cannot be obtained, This Plan may make payment to any individual, or organization that has assumed the care, or principal support for you and is equitably entitled to payment. This Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by This Plan. Any payment made by This Plan in accordance with this provision will fully release This Plan of its liability to you.

## **Right to Investigate Claims**

The Plan Administrator will have the right to request, or release any medical information it deems necessary to properly process a claim.

The Plan Administrator has the right, and opportunity to examine, at its expense, any person whose illness, or injury is the basis of any claim, when and as often as reasonably required and, in the event of death, to obtain an autopsy, unless prohibited by law.

## **Statements not Warranties**

In the absence of fraud, all statements made by the Employer or by a Covered Employee are deemed representations, and not warranties. No statement made by the Employer, or by an Employee for the purpose of obtaining Coverage, will be used to avoid such Coverage, or reduce benefits unless the statement is in writing, and is signed by the Employer, or the Employee and a copy is sent to the Employer, the Employee, or their beneficiary.

## **Clerical Error**

If a clerical error is made, it will not affect the Coverage to which the Covered Member is entitled. A fair adjustment of premiums shall be made, from the date the member notifies the Plan Administrator in writing, when a clerical error has occurred, or a delay in making entries in the records pertaining to the Coverage under the Plan is found. Such an error, or delay will neither void Coverage that is otherwise validly in force, nor continue Coverage beyond the date that Coverage would otherwise terminate.

## **Conformity to Statutes**

This Plan will conform to all applicable State and Federal statutes.

## COORDINATION OF BENEFITS

The benefits that are payable under This Plan for medical, or dental expenses will be coordinated with any other plans that provide the same benefits, so that not more than 100% of the allowable expenses will be covered. The County has the right to gather data, recover sums paid, or repay any party in order to administer the Coordination of Benefits.

### General Provision

When a Covered Member, and/or his Dependents are covered under more than one group vision plan, the combined benefits payable by This Plan, and all other group plans will not exceed 100% of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group vision plan.

When This Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining Eligible Expenses, not to exceed normal Plan liability.

For purposes of coordination, eligible expense means any usual and customary charge considered in part or full by at least one of the plans. However, any expense denied by the primary carrier because the claimant did not comply with the rules governing the primary plan of benefits will not be considered an eligible expense under This Plan.

### Other Group Plans

This Plan coordinates with other plans according to the following rules:

1. Any group vision plan which does not contain a coordination of benefits provision will be primary.
2. A plan covering a person as an Employee will be primary over a plan covering the same person as a Dependent.
3. A plan covering a person as an Active Employee will be primary over a plan covering the same person as either a Retiree or terminated individual.
4. When a person is an Active Employee under more than one plan, the plan covering the individual for the longer period of time will be primary.
5. A plan covering a person as a Dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

### Children of Divorced or Separated Parents

When all plans covering a person as a Dependent child of divorced or separated parents contain a coordination of benefits provision, This Plan coordinates with other plans according to the following rules:

1. If there is a court order establishing which parent has financial responsibility for the child's vision care expenses, that parent's plan (assuming it covers the child as a Dependent), will be primary.
2. If there is no court order, and the parent with legal custody has not remarried, that parent's plan is primary (assuming it covers the child as a Dependent).

## COORDINATION OF BENEFITS (Continued)

3. If there is no court order, and the parent with legal custody has remarried, the plans that cover the child as a Dependent will pay benefits in the following order:
  - a. The plan of the parent with legal custody;
  - b. The plan of a stepparent who is the spouse of the natural parent having legal custody;
  - c. The plan of the parent without custody.

If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

### **HMO's**

There are special coordination of benefit rules that affect Dependents covered under Health Maintenance Organizations (HMOs).

When primary Coverage is through an HMO sponsored by another employer, and This Plan is secondary, This Plan's secondary Coverage will not provide Coverage if you or your Dependents fail to comply with the HMO's regulations regarding providers and services.

The combined benefits from both the HMO plan and This Plan will not total more than the amount This Plan would have paid alone.

### **COBRA Coverage**

Cobra coverage is secondary to any other applicable coverage.

### **Right to Receive and Release Needed Information**

The Plan Administrator will have the right to obtain or give information needed to administer this Plan or coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person. Notice or consent will not be needed to do this.

Any person who claims benefits must furnish the information necessary to coordinate benefit payments to the Plan Administrator.

### **Right to Make Payment**

The Plan Administrator reserves the right to pay any other organization as needed to properly carry out this provision. These payments that are made will be made in good faith, and will be considered benefits paid under This Plan. Also, these payments discharge the Plan Administrator from further liability, to the extent the payments are made.

### **Right of Recovery**

If more benefits were paid than should have been paid, the right to recover the excess amount will be exercised. This can be from the person for whom the payments were made, or from an insurance company, or organization to whom the payment was made.

Further, whenever payments have been made based on fraudulent information provided by a Covered Member, This Plan has the right to withhold payment on future benefits until the overpayment is recovered.

## EXTENSION OF BENEFITS AFTER PLAN TERMINATION

The benefits payable during any period of extension may be subject to the regular benefit limits of This Plan, but shall provide no lesser benefit limits.

### ❖ **Vision**

If This Plan terminates while a Covered Member is Totally Disabled, benefits will be extended for charges incurred after that date. The Covered Member must provide written notice to the Plan of their intention to receive extended benefits within 31-days of the date This Plan terminates. Coverage for the disabling condition will continue without any Employee contribution.

Extended Benefits are payable only for those expenses incurred:

1. for the same Injury or Illness which caused the Covered Member to be Totally Disabled;
2. while the person remains Totally Disabled; and
3. during the first 12-months after the date Coverage terminates under the medical portion of This Plan.

## **SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION**

This section describes the Plan's right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your Covered Dependents if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you or your Covered Dependent may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below:

If a Covered Person incurs expenses covered by the Plan as a result of the act of a third party (person or entity), the Covered Person may receive benefits pursuant to the terms of the Plan. However, the Covered Person is required to refund to the Plan all benefits paid if he recovers from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The Covered Person may be required to:

- a) Execute an agreement provided by the Employer or the Claims Administrator acknowledging the Plan's right of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Covered Person from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Covered Person's cause of action or other right of recovery to the Plan. If the Covered Person fails to execute such an agreement, the Covered Person, by filing claims (assigning benefits or having claims filed on his behalf) related to such act of a third party, shall be deemed to have agreed to the terms of this reimbursement provision;
- b) Provide such information as the Employer, or the Claims Administrator may request;
- c) Notify the Employer and/or the Claims Administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Covered Person to recover damages from a third party;
- d) Agree to notify the Employer and/or the Claims Administrator of any recovery.

The Plan's right to recover the benefits it has paid is subject to reduction for attorney's fees and other expenses of recovery. The reduction is limited to the lesser of actual attorney fees and other expenses or one-third of the Plan's lien. The Plan's right to recover benefits shall apply to the entire proceeds of any recovery by the Covered Person. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (i.e., the Plan has a right of first reimbursement out of any recovery, even if the Covered Person is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the Covered Person and against future benefits due under the Plan in the amount of any claims paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any Covered Person that could be subject to the Plan's right of recovery if and when received by the Covered Person. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

If the Covered Person fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by

## **SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION (Continued)**

assignment or subrogation, a portion of the Covered Person's claim equal to the amounts the Plan has paid on the Covered Person's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to have waived its rights to commence action against a third party if it fails to act after the expiration of one year nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

The Covered Person shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the Covered Person against a responsible third party and the giving of testimony in any action filed by the Plan. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person), or benefits that were obtained through fraudulence, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.

## COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Covered Employees and/or their Covered Dependents described below (called "Qualified Beneficiaries") are entitled to elect to purchase a temporary continuation of health Coverage (called "Continuation Coverage") at group rates in certain instances (called "qualifying events") when Coverage under the Plan would otherwise end.

An Employee covered by the Plan has a right to elect Continuation Coverage if Coverage is lost because of a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment.

The Covered Dependent who is the spouse of a Covered Employee has a right to elect Continuation Coverage (even if the Employee chooses to decline Continuation Coverage) if the Covered Dependent loses group health Coverage under the Plan for any of the following four reasons:

1. The death of the Employee;
2. A termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment;
3. The divorce or legal separation, where recognized, from the Employee; or
4. The Employee becomes entitled to benefits under Medicare.

In the case of a Covered Dependent who is a child of a Covered Employee, such child has the right to elect Continuation Coverage (or the Employee's spouse may elect Continuation Coverage on behalf of the child, even if the Employee chooses to decline Continuation Coverage) if group health Coverage under the Plan is lost for any of the following reasons:

1. The death of the Employee;
2. A termination of the Employee's employment (for reasons other than gross misconduct) or a reduction in the Employee's hours of employment;
3. The Employee's divorce or legal separation, where recognized;
4. The Employee becomes entitled to benefits under Medicare; or
5. The child ceases to be a "Dependent child" under the Plan.

Qualified Beneficiaries have the same rights as similarly situated active employees to change Coverage options and Coverage levels during Open Enrollment or if he experiences a Change in Status or Special Enrollment event.

**ELECTING CONTINUATION COVERAGE.** Provided you or your Covered Dependents have provided any required notice to the Plan Administrator (see below), you or your Covered Dependents will be notified of the right to continue Coverage and provided with the necessary information to complete an election. You and your Covered Dependents will have 60 days from

## COBRA CONTINUATION COVERAGE (Continued)

the date the notice of the right to Continuation Coverage is received (or, if later, 60 days from the date coverage is lost) to complete an election of Continuation Coverage. If the election is not completed within the 60-day period, you will not have Continuation Coverage and will have no further rights to elect such coverage.

Each Qualified Beneficiary may purchase Continuation Coverage by completing and returning the appropriate election forms.

**ADDING NEW DEPENDENTS.** Children born to, adopted by, or placed for adoption with, the Covered Employee during the period of Continuation Coverage will be considered Qualified Beneficiaries and may also receive Continuation Coverage provided they are added within the time required by the Plan after the birth, adoption or placement for adoption.

Other than a child born to, adopted by, or placed for adoption with a Covered Employee during the COBRA period, spouses and dependents added during the COBRA coverage period are not Qualified Beneficiaries, even though the new spouse or dependent may be eligible to be added to the Coverage for the balance of the COBRA coverage period. The Covered Employee must enroll the new spouse and/or dependent within 31 days after the marriage, birth, adoption, or placement for adoption. If COBRA coverage ceases for the Covered Employee before the end of the maximum COBRA coverage period, COBRA coverage also will end for a newly added spouse or dependent child. However, COBRA coverage can continue for a newly added newborn child, adopted child, or child placed with the Covered Employee for adoption until the end of the maximum COBRA coverage period.

If while the Covered Employee is enrolled in Continuation Coverage, his or her spouse or dependent loses coverage under another group health plan, the Covered Employee may add the spouse or dependent to his or her coverage for the balance of the Continuation Coverage period, provided the eligible dependent meets the requirements for special enrollment as described in the "SPECIAL ENROLLMENT" section of this Plan.

Continuation Coverage may also apply to certain covered retirees and their covered dependents in the event of the Employer's bankruptcy under Title 11 of the U.S. Code. Special rules apply for this event.

**COVERED PERSON'S NOTICE REQUIREMENTS.** Under group health plan rules and COBRA law, the Employee, spouse, or other family member has the responsibility to notify the Plan Administrator (County of Volusia, Personnel Division) at:

County of Volusia  
Personnel Division – Benefits Section  
230 N. Woodland Blvd., Ste. 262  
DeLand, FL 32720

386 736-5951 - DeLand  
386 257-6029 - Daytona Beach  
386 423-3300 - New Smyrna

of a divorce, legal separation, where recognized, or a child losing dependent status under the Plan. To protect the Covered Person's Continuation Coverage rights in these situations, this notification must be made within 60 day from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the Plan because of the event.

## COBRA CONTINUATION COVERAGE (Continued)

**NOTICE PROCEDURES.** Procedures for making proper and timely notice are listed below.

1. Contact the Human Resources Department and request a Qualifying Event Notification Form;
2. Complete the Qualifying Event Notification Form;
3. Make a copy of the form for your records;
4. Attach the required documentation depending upon the qualifying event;
5. Hand deliver or mail the notification form to the address listed on the form and document your mailing; and
6. Call within 10 days to insure the notification form has been received.

**If this notification is not completed according to the outlined procedures and within the required 60-day notification period, then rights to Continuation Coverage based on the occurrence of the event will be forfeited.** In addition, failure to notify and thereby causing the Plan to continue coverage of an individual who has in fact become ineligible may be considered fraud on the part of the Employee.

The Covered Person must also notify the Plan Administrator of the current address of the individual losing coverage. This is the address where the COBRA notice will be sent. Once it is notified, the Claims Administrator will, in turn, notify the eligible COBRA participant that he or she has the right to elect Continuation Coverage.

**EMPLOYER'S NOTICE REQUIREMENTS.** If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both) or a commencement of a bankruptcy proceeding, the Covered Person will be notified that he or she has the right to elect Continuation Coverage. The eligible COBRA participant has 60 days from the date of the COBRA notice (or, if later, 60 days from the date Coverage is lost because of one of the qualifying events described above) to elect Continuation Coverage.

**TRADE ADJUSTMENT ASSISTANCE.** An Employee may have the right to a second COBRA election period if the Employee was entitled to elect COBRA coverage and did not do so during the original COBRA election period. To qualify, the Employee must be receiving trade adjustment assistance (eligibility requires a government certification under the 1974 Trade Act) and must have lost his or her Coverage under the Plan because of a job loss that resulted in his or her eligibility for trade adjustment assistance. The Employee's new 60-day COBRA election period will begin the first day of the month in which he or she begins receiving trade adjustment assistance, but it will not extend more than six months after his or her initial loss of Coverage under the Plan. If the Employee elects COBRA coverage during this second election period and after the end of the initial election period, his or her Continuation Coverage will begin on the first day of the second election period. The Employee's Continuation Coverage will not be retroactive to the date of the initial loss of Coverage. The period of time between the Employee's loss of Coverage that resulted in his or her eligibility for trade adjustment assistance and the date he or she began receiving trade adjustment assistance will not be counted in determining whether he or she has a 63-day break in Coverage for purposes of applying any Pre-existing Condition Limitation under the Plan.

**TYPE OF COVERAGE.** If timely and properly elected and paid, Continuation Coverage will be provided to Qualified Beneficiaries in a manner identical to Coverage provided under the Plan to similarly situated Covered Persons who are not Qualified Beneficiaries.

## COBRA CONTINUATION COVERAGE (Continued)

**LENGTH OF CONTINUATION COVERAGE.** The length of Continuation Coverage depends upon the type of qualifying event and who the Qualified Beneficiary is. If you are on an approved military leave that lasts longer than 30 days, your Continuation Coverage can last up to 24 months. In the case of a loss of coverage due to the end of employment or the reduction in hours of employment, Continuation Coverage can last up to 18 months. In the case of a loss of coverage due to the Covered Employee's death, divorce or legal separation, the Covered Employee's becoming entitled to Medicare or a dependent child ceasing to qualify as a Dependent under the terms of the Plan, Continuation Coverage may last for up to 36 months (provided that the Qualified Beneficiary submitted written notice of divorce, legal separation or dependent child ceasing to be a dependent within 60 days of the later of the date of the event or the date coverage is lost as a result of the event). When the qualifying event is the end of employment or reduction in hours of employment, and the Covered Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for Qualified Beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can extend up to 36 months after the date of Medicare entitlement.

**SECOND QUALIFYING EVENTS.** The maximum duration of Continuation Coverage based on termination of employment or reduction in hours may be extended from 18 months to 36 months if a second event entitling a Covered Dependent to Continuation Coverage (such as a death, divorce, legal separation (where recognized), the Employee's Medicare entitlement or a child losing Dependent status under the Plan) occurs during that 18-month period (or the first 29 months of continuation coverage in the case of a disability extension). To qualify for this extension, the Employee or Covered Dependent must notify the Employer within 60 days after the second event. In providing this notice, you must follow the notice procedures specified above. You are entitled to an extension only if the event would have caused a spouse or dependent child of an active employee to lose coverage under the Plan. If the Employee or Covered Dependent does not notify the Employer within the 60-day period, the Covered Dependent will not be entitled to extend the maximum period from 18 months to 36 months.

**DISABILITY DETERMINATION.** For certain disabled Qualified Beneficiaries, Continuation Coverage may be available for up to a total of 29 months from the date of the qualifying event. If you or your Covered Dependent elect Continuation Coverage for reasons due to termination of employment or reduction of hours, and are deemed disabled by the Social Security Administration before, on, or within 60 days of the date the Continuation Coverage became effective, you and your Covered Dependents may be eligible for up to an additional 11 months of Continuation Coverage. You must notify the Claims Administrator within 60 days of the date of the Social Security disability determination and before the end of the initial 18-month COBRA period. You must also notify the Claims Administrator within 30 days of the Social Security Administration's determination that you (or your Covered Dependent) are no longer disabled.

If the individual entitled to the disability extension (described in the preceding paragraph) has nondisabled family members who have Continuation Coverage due to the same qualifying event, those nondisabled family members will also be entitled to this 11-month disability extension. If a child is born to or adopted (or placed for adoption) by you while you are continuing coverage and the child is determined to be disabled within the first 60 days of Continuation Coverage, the child and all family members with Continuation Coverage arising from the same qualifying event may be eligible for a total of up to 29 months of Continuation Coverage.

**UNIFORMED SERVICES.** Pursuant to the Veterans Benefits Improvement Act 2004 (VBIA), Members of the Uniformed Services and their families are entitled to health coverage under TRICARE, the military health program. If a Covered Employee takes a leave of absence to perform services in the

## COBRA CONTINUATION COVERAGE (Continued)

Uniformed Services that is expected to last 31 days or more (as addressed in the Uniformed Services Employment and Reemployment Act (USERRA)), employers must offer employees called to active service the right to continue their employer-provided health coverage for themselves and their dependents for a period of up to 24 months.

**TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD.** In all cases, Continuation Coverage will end for any of the following reasons:

1. Employer no longer provides group health coverage for any of its Employees;
2. Appropriate payment for Continuation Coverage is not made timely;
3. After the date of the COBRA election, the Employee or Dependent becomes covered under another group health plan that does not contain a pre-existing condition exclusion or limitation which affects them (under the HIPAA portability laws, the time the other health plan can exclude coverage for pre-existing conditions may be reduced by the period of time during which you had coverage for the condition under a previous health plan, including Continuation Coverage);
4. After the date of the COBRA election, the Employee or Dependent becomes entitled to Medicare;
5. The Employee and/or Dependents previously extended continuation coverage beyond 18 months due to a Social Security disability, and a final determination has been made that the Qualified Beneficiary is no longer disabled;
6. A Qualified Beneficiary notifies the Employer he wishes to cancel COBRA Continuation Coverage; or
7. Any other event that would cause a Covered Person who is not on Continuation Coverage to lose Coverage under the Plan.

Written health evidence is not required to elect Continuation Coverage.

**PAYING FOR CONTINUATION COVERAGE.** Initial payment for Continuation Coverage must be made within 45 days from the date of Continuation Coverage election. This initial payment must pay for all months of coverage from the date of the qualifying event up to and including the month in which the payment is made. Continuation Coverage will not become effective until the full and correct initial payment is made and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid by 30 days following the due date, in which event Continuation Coverage will cease, without notice, retroactive to the first day of the month for which payment has not been made. A check that is dishonored for any reason will not be considered payment.

**COST OF CONTINUATION COVERAGE.** Qualified Beneficiaries must pay the entire cost of Continuation Coverage, including an additional 2% charge to cover administrative expenses. Required contribution for any part of the additional 11 months of Continuation Coverage due to disability may be increased up to 150% of the applicable premium if the disabled Qualified Beneficiary elects the extension. If only non-disabled Qualified Beneficiaries elect the extension, the applicable premium will remain at the 102% rate.

## **COBRA CONTINUATION COVERAGE (Continued)**

**NOTIFICATION OF ADDRESS CHANGE.** To ensure all Covered Persons receive information properly and efficiently, it is important that you notify FSAI at the address listed below of any address change for you or your Dependent as soon as possible. Failure on your part to do so may result in delayed COBRA notifications or the loss of Continuation Coverage options.

**FSAI  
780 W. Granada Blvd., Suite 250  
Ormond Beach, FL 32174**

Once Coverage under COBRA terminates, no other Coverage is available under this or any other plan offered by The County of Volusia.

## PLAN INFORMATION

**Name of Plan:** County of Volusia

**Name and Address of the Plan Administrator:** County of Volusia  
Personnel Division  
230 North Woodland Blvd., Ste. 262  
DeLand, FL 32720

**Employer I.D. Number (EIN):** 59-6000885

**Plan Number:** 2081

**Plan Year:** January 1 to December 31

**Revised Effective Date:** January 1, 2011

**Type of Plan:** Self-Funded Group Vision Benefit Plan

**Type of Participants:** All regular full-time, permanent part-time Employees in regularly established positions.

**Claims Administrator:** FSAI  
780 W. Granada Blvd., Suite 250  
Ormond Beach, FL 32174

**Method of Funding Benefits:** Benefits are self-funded from contributions from the Employer and Employees.

**Self-Funded Disclosure:** The Vision Coverage described in this Summary Plan Description is provided under as a self-funded Plan. Single employer self-funded plans are not regulated by the Florida Department of Insurance. The payment of claims is completely dependent upon the financial solvency of your Employer, and no guaranty fund exists to cover claims a bankrupt or insolvent employer cannot pay.

However, in order to reduce the risk of unexpected, catastrophic claims loss to your Plan, your Employer has purchased excess loss coverage which provides reimbursement to your Plan in excess of certain dollar amounts.

**Termination or Amendment:** The County of Volusia intends to maintain This Plan indefinitely. However, the County Manager reserves the right to terminate, suspend, discontinue, or amend This Plan at any time. You will be notified in advance of any changes affecting your Coverage under This Plan.

## DEFINITIONS

This section defines some of the specific terms used in This Plan. The following definitions should not be interpreted to extend Coverage and are defined for reference only. Not all of the definitions may apply to This Plan.

Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

**Affordable Care Act.** The patient Protection and Affordable Care Act (H.R. 3590) was signed into law on March 23, 2010. The companion bill, the Healthcare and Education Reconciliation Act (H.R. 4872), as signed into law on March 30, 2010. Together, these two bills constitute what is referred to as the "Affordable Care Act" or ACA."

**Amendment** means a formal document signed by the representatives of This Plan. The Amendment changes the provisions of This Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

**Annual Open Enrollment Period** means the only period of time in which an Employee can enroll for Coverage or add Dependent Coverage, except for valid Status Changes. Open Enrollment is usually the month of November.

**Claims Administrator** is FSAI, 780 W. Granada Blvd., Ste 250, Ormond Beach, FL 32174.

**Coverage** means any Coverages provided herein.

**Covered Employee; Covered Dependent; Covered Person; Covered Member** means an eligible participant whose Coverage became effective and has not terminated, including those eligible participants who elected to continue Coverage through the COBRA Continuation Coverage provision.

**Covered Service** means vision treatment performed, ordered, furnished or prescribed by an Ophthalmologist, Optometrist, or Optician acting within the scope of his license.

**Dependent** means the Covered Employee's spouse and children.

The term "***spouse***" means the legally recognized marital partner, excluding the domestic partner, of a Covered Employee. The term shall exclude such spouse who has divorced the Employee, or who is legally separated from the Employee.

The term "***children***" means natural children, step-children, foster children, or children who have been placed under legal guardianship and legally adopted children from birth to age 26 (whether married or unmarried). This applies to any children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

The Plan may choose to not extend coverage for adult children who are eligible for coverage under another employer-sponsored group health plan (other than another parent's plan), but only for plan years beginning before 1/1/14. This does not apply to stand alone dental and vision plans but Employer may voluntarily extend dependent coverage to adult children in such plans.

Note: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Health Partnership Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Personnel Division at 386-736-5951.

## DEFINITIONS (Continued)

The term "**children**" also means pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, irrespective of whether the adoption has become final, and with no pre-existing conditions limitations applied provided the Dependent is under age 19 and is enrolled in a timely manner as stated within.

The term "**children**" also means a Covered Member's child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under This Plan as an "alternate recipient." The HPP Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609, and within a reasonable time after receiving an order will determine whether or not the order is qualified, and whether or not the child has been determined to be an "alternate recipient." The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

A child determined to be an "**alternate recipient**" will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, with no pre-existing conditions limitations applied provided the Dependent is under age 19 and is enrolled in a timely manner as stated within.

All children are eligible for Coverage until the end of the calendar year in which the child reaches the age of 26. However a child will remain a Dependent until the end of the calendar year in which the child reaches the age of 30, even after leaving college and home, so long as the young adult meets the following conditions:

- Must either live in Florida or be a full-time or part-time student whose parent resides in Florida;
- Must not be married;
- Must not have a dependent of his or her own;
- Must not be covered by another health plan or policy (group or individual) or by Medicare; and
- If the child was covered under the parent's health insurance policy up to the age of 26, and that coverage was subsequently terminated, the child must have been continuously covered by other health insurance without a gap in coverage of more than 63 days in order to re-enroll in the parent's health insurance policy.

Dependent children from age 27 to 30 will incur additional cost for the coverage, see your Benefits Department for details.

If the employee fails to notify the HPP Administrator, in writing within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

**Special Exception for Medical Necessity (Michelle's Law):** Notwithstanding the foregoing a covered Employee's unmarried child will not immediately lose eligibility to participate in the Plan if such child loses his or her required student status as a result of a change in enrollment (included a leave of absence) that (i) is medically necessary and (ii) commences while the child is suffering from a serious illness or injury. This special exception for medical necessity will delay termination of coverage until the earlier of one year from the first day of the medically necessary leave of absence or the date that the Dependent would otherwise lose coverage under the Plan for reasons other than student status (e.g. age limitations), unless the child regains full-time student status prior to such termination date.

The term **Dependent** also includes an Employee's unmarried child while the child is Physically, or Mentally Handicapped and is incapable of earning his own living, and who is actually dependent on

## DEFINITIONS (Continued)

either parent for a majority of his maintenance and support, and who is a Covered Member on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the HPP Administrator within 31-days of the date his health Coverage would have terminated due to age.

In the event both parents of an eligible Dependent child are Covered Members, then for the purposes of this Coverage, such child is considered as a Dependent of either parent, but not both parents.

No eligible person can be a Covered Employee, and a Covered Dependent at the same time. No person can be covered as a Dependent of more than one Employee.

**Eligible Charges; Eligible Expenses; Covered Expenses; Covered Charges; Covered Service** means a vision treatment or procedure given by, or under the direction of, a licensed Ophthalmologist, Optometrist or Optician of an approved type usually provided for the condition being treated and for which Coverage is provided under This Plan.

**Employee** means a person who is directly employed in the regular business of and compensated for services by the Employer or any subsidiary or affiliate, and who actively expends time and energy in the service of the Employer at the Employer's usual place of business or some other location which is usual for the Employee's particular duties, other than the Employee's home.

**Employer** means County of Volusia.

**Leave of Absence** means a period of time, of stated duration, during which the Employee does not work but after which time the Employee is expected to return to active work.

**Medicare** means Title XVIII (Health Insurance for the aged) of the United States Social Security Act as amended.

**Ophthalmologist** means a licensed doctor of medicine (M.D.), or a licensed doctor of osteopathy (D.O.) who is legally qualified to practice medicine, including the diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

**Optician** means a person who makes or sells eyeglasses and/or contact lenses prescribed by an Ophthalmologist or Optometrist to cure or correct defects in the eyes; grinds lenses, or has them ground according to prescription, fits them into a frame, and adjust the frame to fit the face.

**Optometrist** means a person licensed to practice optometry as defined by the laws of the state in which the service is rendered.

**Physician** means a person acting within the scope of his/her license and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered. The term includes, but is not limited to, those holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Optometrics.

**Plan Administrator** means the person or organization responsible for the day-to-day functions and management of This Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

The Plan Administrator for This Plan is County of Volusia, 230 N. Woodland Blvd., Ste. 262, Deland, FL 32720.

## DEFINITIONS (Continued)

**Plan; This Plan** whenever used herein without qualification will mean the Plan of benefits as contained in this Summary Plan Description and in any agreements, schedules and Amendments endorsed by the Employer.

**Practitioner** means a person acting within the scope of applicable state licensure/certification requirements and performing a service for which benefits are provided under the Plan.

**Prescription** means a direct order for the preparation and use of lenses. This order may be given verbally or in writing by a Physician for the benefit of and use by a Covered Member. The lenses must be obtainable only by Prescription. The Prescription must include the name and address of the Covered Member for whom the Prescription is intended, the type lens prescribed, and the directions for its use, the date the Prescription was prescribed; and the name and address of the prescribing Physician.

**Surgery or Surgical Procedure** means any of the following procedures (excluding oral Surgical Procedures):

1. incision, excision or electrocauterization of any organ or body part;
2. reconstruction of any organ or body part or the suture repair of lacerations;
3. reduction of a fracture or dislocation by manipulation;
4. use of endoscopic procedure to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. puncture for aspiration;
6. injection for contrast media testing; or
7. laser Surgery.

Same Incision means all surgeries performed using one (1) incision.

Separate Incisions means surgeries performed using two (2) or more incisions.

Operative Field means the exposed area of the body which has been scrubbed or sterilized.

Separate Operative Fields means two (2) or more separate areas of the body which have been surgically scrubbed or sterilized.

Incidental Procedure means a procedure for which an additional charge is not reasonable. These procedures include, but are not limited to, incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.

Independent Procedure means a procedure that is performed independently and is not immediately related to other services.

# PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

## **Group Health Plan's Designation of Entity to Act on its Behalf.**

The **County of Volusia Health Partnership Plan** (the Plan) has determined that it is a Group Health Plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor, **County of Volusia**, to take all actions required to be taken by the Group Health Plan in connection with the HIPAA Privacy Rule.

This Section applies to the Plan solely to the extent it provides medical, dental, vision, and any other benefits that constitute group health plan benefits under 45 C.F.R. §160.103, and does not apply to any non-health benefits or benefits that provide or pay for the cost of excepted benefits that are listed in 42 U.S.C. §300gg 91(c)(1).

## **A. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

(1) The Plan will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(2) Disclosure to the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of written certification from the Plan Sponsor that:

- (a) The Plan document has been amended to incorporate the provisions in this Section; and
- (b) The Plan Sponsor agrees to implement the provisions in Subsection B below.

**B. CONDITIONS IMPOSED ON PLAN SPONSOR.** Notwithstanding any provision of the Plan to the contrary, the Plan Sponsor agrees:

(1) Not to use or disclose PHI other than as permitted or required by this Section or as required by law;

(2) To 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 PHI received or created on behalf of the Plan and ensure that such individuals agree to implement reasonable and appropriate security measures to protect electronic PHI;

(3) Not to use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual. Notwithstanding this paragraph (3), the Plan Sponsor may use enrollment, disenrollment and eligibility information as permitted by 45 C.F.R. Parts 160-164 to perform enrollment and disenrollment functions.

(4) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Plan Sponsor unless authorized by the Individual;

(5) To report to the Plan any use or disclosure of PHI that is inconsistent with this Section or any Security Incident, if it becomes aware of an inconsistent use or disclosure. Security Incident includes reporting for both attempted and successful unauthorized access, use, disclosure,

## **PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (Continued)**

modification, and destruction of information, or interference with system operations. As a result, the Plan Sponsor shall report the aggregate number of unsuccessful, unauthorized attempts to access, use disclose, modify or destroy electronic Protected Health Information or interfere with systems in operations in an information system containing electronic Protected Health Information. These reports will be provided only as frequently as the Plan and the Plan Sponsor mutually agree, but no more than once per month. For any successful unauthorized, attempts to access, use disclose, modify or destroy electronic Protected Health Information or interfere with systems in operations in an information system containing electronic Protected Health Information, the Plan Sponsor shall report in writing any such use or disclosure to the Plan as soon as administratively possible;

(6) To provide Individuals with access to PHI in accordance with 45 C.F.R. §164.524;

(7) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;

(8) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(9) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(10) If feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(11) To ensure adequate separation supported by reasonable and appropriate security measures is implemented between the Plan and the Plan Sponsor as required by 45 C.F.R. §164.504(f)(2)(iii) and described in this Section; and

(12) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan.

**C. DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI.** In accordance with the Privacy Rules, only certain, designated Employees who perform Plan administrative functions may be given access to PHI. Those Employees or class of Employees who have access to PHI are as follows (or their equivalents and successors within the Plan Sponsor's workforce):

(1) Benefits Department;

(2) Privacy Official;

(3) Members of the Corporate in-house legal staff who have limited access to Participant's PHI for purposes of assisting with Plan interpretation; and

(4) Members of the Payroll and Information Technology Departments who have limited access to Participant's PHI.

## **PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (Continued)**

**D. RESTRICTIONS ON EMPLOYEES WITH ACCESS TO PHI.** The Employees who have access to PHI may only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, monitoring, and management of the Plan and coordination with other benefits.

**E. POLICIES AND PROCEDURES.** On or before the effective date of the Privacy Rules, the Plan Sponsor shall have implemented Policies and Procedures setting forth operating rules to implement the provisions hereof.

**F. ORGANIZED HEALTH CARE ARRANGEMENT.** It is intended that the Plan may form part of an Organized Health Care Arrangement.

**G. HYBRID ENTITY DESIGNATION.** The Plan Administrator intends the Plan to be a Hybrid Entity in accordance with 45 C.F.R. §164.504(b) and only those benefits that would be a covered health plan under 45 C.F.R. §160.103 (if set forth as a separate plan) will constitute the health care components of the Plan. Any benefit offered by the Plan that would not be a covered health plan under 45 C.F.R. §160.103 if provided through a separate plan is a non-health care component of the Hybrid Entity and is not subject to the Privacy Rules.

**H. PRIVACY OFFICIAL.** The Plan shall designate a Privacy Official, who will be responsible for the Plan's compliance with the privacy provisions of HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

(1) Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section;

(2) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Plan Sponsor;

(3) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the Privacy Rules;

(4) Establishing and overseeing proper training of the Plan, or the Plan Sponsor personnel who will have access to PHI; and

(5) Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the Privacy Rules and the purposes of this Section.

**I. SECURITY OFFICIAL.** The Plan shall designate a Security Official, who will be responsible for the Plan's compliance with the security provisions of HIPAA. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Security Official shall have the authority to and be responsible for:

## **PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (Continued)**

- (1) Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section;
- (2) Transmitting the certification to any third parties as may be necessary to permit them to disclose electronic PHI to the Plan Sponsor;
- (3) Establishing and implementing policies and procedures with respect to electronic PHI that are designed to ensure compliance by the Plan with the security requirements of HIPAA;
- (4) Establishing and overseeing proper training of the Plan, or Plan Sponsor personnel who will have access to electronic PHI; and
- (5) Any other duty or responsibility that the Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the security provisions of HIPAA and the purposes of this Section.

**J. NONCOMPLIANCE.** The Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Section.

**K. INTERPRETATION AND LIMITED APPLICABILITY.** This Section serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Section nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Section are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

**L. SERVICES PERFORMED FOR THE PLAN SPONSOR.** Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Plan Sponsor in its capacity as Plan sponsor and not on behalf of the Plan.

**M. DEFINITIONS.** As used in this Section, each of the following capitalized terms shall have the respective meaning given below:

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

**Individual** means the person who is the subject of the health information created, received or maintained by the Plan or the Plan Sponsor.

**Organized Health Care Arrangement** means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.

## PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (Continued)

**Privacy Notice** means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. §164.520, as amended from time to time.

**Privacy Rules** means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

**Protected Health Information (PHI)** means individually identifiable health information as defined in 45 C.F.R. §160.103.

**Security Incident** means an incident as defined in 45 C.F.R. §164.304.