Prime Healthcare Welfare Benefits Plan and

Prime Healthcare Foundation Welfare Benefits Plan

Wrap Document

Effective January 1, 2020

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ARTICLE I.

ESTABLISHMENT AND INTERPRETATION OF THE PLAN

1.1 The Plan.

The terms and conditions of the Prime Healthcare Welfare Benefits Plan and Prime Healthcare Foundation Welfare Benefits Plan are set forth in this document ("Wrap Document") and in the Welfare Program Documents. The Wrap Document and the Welfare Program Documents together constitute the Prime Healthcare Welfare Benefits Plan and Prime Healthcare Foundation Welfare Benefits Plan and the written instrument under which it is maintained for purposes of section 402(a) of ERISA.

1.2 Purpose and Intent.

The purpose of the Plan is to provide Participants and Beneficiaries certain welfare benefits described herein. The Welfare Programs incorporated herein shall be treated as a single welfare plan for purposes of ERISA. The Plan is intended to satisfy all applicable requirements of the Code and ERISA, as well as rulings and regulations issued or promulgated thereunder. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions to the extent not otherwise applicable.

Only Prime Healthcare, the Plan Administrator, or its designee is authorized to interpret the Plan. Employees and Beneficiaries should not rely on any representation, whether oral or in writing, that any other individual may make concerning Plan provisions and their entitlement to benefits under the Plan.

1.3 Definitions.

When used herein, the following words shall have the meanings set forth below unless the context clearly indicates otherwise:

(a) "Administrator" as defined in section 3(16)(A) of ERISA means the Committee, as described in Section 7.1.

(b) "Beneficiary" means a covered person, dependent, member and beneficiary of a Participant as designated or determined under a Welfare Program.

(c) "Employee" means any person treated by the Employer as providing services to such Employer as a common law employee. "Employee" does not include:

(i) Any individual who performs services for the Employer pursuant to a leasing agreement between the Employer and a third-party, as defined in section 414(n) of the Code, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer;

(ii) Any individual who is not eligible for coverage as described in the Welfare Program Documents, regardless of whether such individual is later determined

by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer; and

(iii) Any individual who performs services for the Employer and is working in a classification described as independent contractor, is paid directly or indirectly through the Employer's accounts payable systems, or performs such services pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant, regardless of whether any such individual is later determined by a court or any governmental or administrative agency to be, or to have been a common law employee of the Employer.

(d) "Code" means the Internal Revenue Code of 1986, as amended from time-to-time, and any subsequent Internal Revenue Code. References to any section of the Code shall be deemed to include similar sections of the Code as renumbered or amended.

(e) "Dependent" means a covered dependent of an Employee, as determined under a Welfare Program.

(f) "Employer" means Prime Healthcare and its participating entities or any successor entity by merger, consolidation, purchase or otherwise.

(g) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time-to-time. References to any section of ERISA shall be deemed to include similar sections of ERISA as renumbered or amended.

(h) "Former Employee" means any person formerly employed by the Employer as an Employee.

(i) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time-to-time.

(j) "Leave of Absence" means a personal leave, medical leave or military leave of an Employee, as approved by the Employer employing the Employee.

(k) "Participant" means any Employee or Former Employee who satisfies the requirements of Article II, is covered by one or more of the Welfare Programs under the Plan, and whose participation has not terminated in accordance with Section 2.4. The term "Participant" shall also include any former Dependent who is entitled to elect, and so elects, any continuation coverage on his or her own behalf.

(l) "Participant Contributions" means any pre-tax or after-tax contributions required to be paid by a Participant for coverage under any Welfare Program.

(m) "Plan" means the Prime Healthcare Welfare Benefits Plan and Prime Healthcare Foundation Welfare Benefits Plan as set forth in this Wrap Document and the Welfare Program Documents, as amended from time-to-time.

(n) "Plan Sponsor" as defined in section 3(16)(B) of ERISA means the Prime Healthcare entities identified as Plan Sponsors herein or any successor entity by merger, consolidation, purchase or otherwise.

(o) "Plan Year" means the 12-consecutive month period beginning each January 1 and ending on the following December 31.

(p) "Summary Plan Description" means the summary plan description(s) for the Plan, as required by ERISA.

(q) "Third-Party Administrator" means any insurer, third-party administrator or other entity selected by the Committee for the administration of the Plan, including initial and/or appeals claims administration, under a self-insured Welfare Program.

(r) "Welfare Program" means the employee welfare benefits offered as part of the Plan, identified in Appendix A, and as described in the Welfare Program Documents.

(s) "Welfare Program Documents" means (i) all provisions of any summary plan description for the Plan that set forth terms and conditions of the Welfare Programs, including without limitation the following sections of the Summary Plan Description: eligibility and enrollment; medical benefits; prescription drug program; dental benefits; vision benefits; health care flexible spending account; limited purpose flexible spending account; health reimbursement account; life insurance benefits; accidental death & dismemberment (AD&D) insurance benefits; short-term disability benefits; long-term disability benefits; COBRA; claims procedures; plan administration; rights under the Plan, contact information; (ii) any and all insurance policies and certificates of insurance and other documents that set forth the terms and conditions of an insured Welfare Program; and (iii) any and all benefits books, guides or other formal documents provided by Third-Party Administrators of any self-insured Welfare Programs. Any amendment to a Welfare Program Document will constitute automatically an amendment to the Plan. The Cafeteria Plan is not a Welfare Program Document and is not part of the Plan.

1.4 Incorporation.

The terms and conditions, including any limitations or restrictions, of each Welfare Program as set forth in the applicable Welfare Program Documents are incorporated by reference in this Wrap Document and constitute part of the Plan.

1.5 Interpretation.

If there is a conflict between a specific provision under this Wrap Document and the Welfare Program Documents, this Wrap Document controls. If this Wrap Document is silent, the applicable Welfare Program Document controls. With respect to fully-insured benefits, the terms of the certificate of insurance coverage control over the Wrap Document and any other Welfare Program Document when describing specific benefits that are covered or insurance-related terms.

1.6 Effective Date.

The effective date of this Wrap Document is January 1, 2020.

1.7 Solicitud de Informacion en Español (Spanish Language Offer of Assistance).

Este documento está escrito en inglés y contiene un resúmen de los derechos y beneficios de su plan de seguro. Si usted tiene dificultad en comprender cualquier parte de este documento, comuníquese con los administradores de:

PRIME HEALTHCARE
3480 E. GUASTI ROAD
ONTARIO, CA, 91761
TELEPHONE: (909) 235-4400

IMPORTANT: ERISA is Federal law. It is not intended that this document provide information that is mandated under any state insurance code. State-mandated benefits and information are as included in the Welfare Program Documents issued by the respective insurance carrier.

With regard to COBRA continuation of coverage rights, please examine the options carefully before declining COBRA coverage. Where COBRA applies, the COBRA provisions that are in the respective Welfare Program Documents will supersede any COBRA provisions in this document.

A voluntary termination of existing COBRA continuation coverage does not trigger a mid-year "special enrollment right" under another group health plan.

For further information, please contact:

PRIME HEALTHCARE
3480 E. GUASTI ROAD
ONTARIO, CA 91761
TELEPHONE: (909) 235-4400

ARTICLE II.
GENERAL PLAN INFORMATION

2.1 Plan Identifying Information.

NAME OF PLAN (actual name)	**Prime Healthcare Welfare Benefits Plan**
PLAN NUMBER	**501**
PLAN SPONSOR	**Prime Healthcare Services, Inc.**
Address	**3480 E. Guasti Road, Ontario, CA 91761**
Phone Number	**(909) 235-4400**
The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by Participants and Beneficiaries upon written request to the Administrator, and is available for examination by Participants, and Beneficiaries as required by ERISA.	
TYPE OF PLAN / TYPE OF BENEFITS	**Welfare Benefits Plan**
	To the extent that the Plan includes group health benefits, the Plan is a group health plan which is subject to HIPAA.
TYPE OF ADMINISTRATION	(see the **Welfare Program Documents** for this information)
PLAN YEAR	**January 1 through December 31**
PLAN SPONSOR TAX ID NUMBER	**33-0943449**
PLAN ADMINISTRATOR	**Prime Healthcare Services, Inc.**
Business Address	**3480 E. Guasti Road, Ontario, CA 91761**
Business Phone Number	**(909) 235-4400**
NAMED FIDUCIARY (see NOTE)	**Prime Healthcare Services, Inc.**
Address	**3480 E. Guasti Road, Ontario, CA 91761**
NOTE: For any Welfare Program that is fully insured (i.e., provided through a licensed insurance company), the insurance company is the Named Fiduciary for benefit determination purposes. See the applicable Welfare Program Documents for the identity of any such company.	
AGENT FOR SERVICE OF PROCESS	**General Counsel Prime Healthcare**
Address Where Process May be Served	**3480 E. Guasti Road, Ontario, CA 91761**
Service of legal process may also be made on the Plan Administrator.	
ORIGINAL PLAN EFFECTIVE DATE	**January 1, 2007**
A complete list of participating hospitals is available upon request.	

NAME OF PLAN (actual name)	**Prime Healthcare Foundation Welfare Benefits Plan**
PLAN NUMBER	**507**
PLAN SPONSOR	**Prime Healthcare Foundation, Inc.**
Address	**3480 E. Guasti Road, Ontario, CA 91761**
Phone Number	**(909) 235-4400**
The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by Participants and Beneficiaries upon written request to the Administrator, and is available for examination by Participants, and Beneficiaries as required by ERISA.	

<table>
<tr><td rowspan="2">TYPE OF PLAN / TYPE OF BENEFITS</td><td>Welfare Benefits Plan</td></tr>
<tr><td>To the extent that the Plan includes group health benefits, the Plan is a group health plan which is subject to HIPAA.</td></tr>
<tr><td>TYPE OF ADMINISTRATION</td><td>(see the Welfare Program Documents for this information)</td></tr>
<tr><td>PLAN YEAR</td><td>January 1 through December 31</td></tr>
<tr><td>PLAN SPONSOR TAX ID NUMBER</td><td>20-8065139</td></tr>
<tr><td>PLAN ADMINISTRATOR</td><td>Prime Healthcare Foundation, Inc.</td></tr>
<tr><td>Business Address</td><td>3480 E. Guasti Road, Ontario, CA 91761</td></tr>
<tr><td>Business Phone Number</td><td>(909) 235-4400</td></tr>
<tr><td>NAMED FIDUCIARY (see NOTE)</td><td>Prime Healthcare Foundation, Inc.</td></tr>
<tr><td>Address</td><td>3480 E. Guasti Road, Ontario, CA 91761</td></tr>
<tr><td colspan="2">NOTE: For any Welfare Program that is fully insured (i.e., provided through a licensed insurance company), the insurance company is the Named Fiduciary for benefit determination purposes. See the applicable Welfare Program Documents for the identity of any such company.</td></tr>
<tr><td>AGENT FOR SERVICE OF PROCESS</td><td>General Counsel Prime Healthcare</td></tr>
<tr><td>Address Where Process May be Served</td><td>3480 E. Guasti Road, Ontario, CA 91761</td></tr>
<tr><td colspan="2">Service of legal process may also be made on the Plan Administrator.</td></tr>
<tr><td>ORIGINAL PLAN EFFECTIVE DATE</td><td>January 1, 2018</td></tr>
<tr><td colspan="2">A complete list of participating hospitals is available upon request.</td></tr>
</table>

2.2 Plan Records. The records of the Plan are kept on the basis of the Plan Year.

2.3 Employer Contributions.

The Employer may make payments or contributions in such amounts and at such times as the Plan Sponsor shall from time-to-time direct. Such payments or contributions may be paid directly to each insurance company issuing a policy or contract in connection with an insured Welfare Program or may be used to pay benefits directly (including through a Third-Party Administrator) in the case of benefits under a self-insured Welfare Program. Nothing herein shall require the Employer to make payment or contribute to any Welfare Program or to pre-fund any benefit through any trust or otherwise.

2.4 Participant Contributions.

Participation in the Plan and the payment of Plan benefits shall be conditioned on a Participant contributing to the Plan such amounts as the Plan Sponsor shall establish from time-to-time. The Plan Sponsor may establish different contribution rates for different classes of Employees, Former Employees, Participants, Dependents, or Beneficiaries from any Welfare Program. The Plan Sponsor may require that any Participant Contributions be made by payroll deduction.

2.5 Salary Reduction.

Required Participant Contributions under the Plan may be made on a pre-tax basis through salary reductions, to the extent permitted by Code section 125 and the Cafeteria Plan. All other

Participant Contributions will be made on a post-tax basis, except to the extent the Code is amended to provide otherwise.

2.6 Funding.

Nothing herein shall require the deposit of any Employer payments or contributions or Participant Contributions to a trust. No Employee, Former Employee, Participant, Dependent or Beneficiary shall have any right to, or interest in, the assets of the Plan Sponsor or any Employer, or the assets of any trust or any other funding vehicle of the Plan.

2.7 Insurance.

The Administrator may, but shall not be required to, insure any of the benefits provided by a Welfare Program. To the extent the Administrator elects to purchase insurance, any such insured benefits shall be the sole responsibility of the insurer, and neither the Plan Sponsor, nor the Plan shall have the responsibility for the payment of such benefits. In the event that any insurer pays dividends, rebates, demutualization proceeds or similar payments, such amounts shall be paid to the Plan Sponsor to the extent permitted by law unless the Plan Sponsor elects to contribute such amounts to the Plan.

2.8 Benefits.

Benefits under each Welfare Program (including limitations and restrictions) will be determined by the Administrator, Third-Party Administrator or insurer, as applicable, in its discretion pursuant to the terms of the applicable Welfare Program Documents.

2.9 Reimbursement, Recovery of Overpayment, and Subrogation.

As a condition for receiving benefits under the Plan, each Participant, Dependent and Beneficiary agrees to and grants the Plan the rights of reimbursement, recovery of overpayment and subrogation. To the extent that a Welfare Plan Document also contains provisions regarding reimbursement, recovery of overpayment, and/or subrogation, this Section and the applicable provisions of such Welfare Plan Document shall both apply so as to grant the Plan the greatest possible rights.

2.10 Coordination of Benefits.

As a condition for receiving benefits under the Plan, each Participant, Dependent and Beneficiary agrees to and grants the Plan the right to coordinate its payment of medical benefits with other plans so that the total medical benefits paid by the Plan together with other plans does not exceed the level of benefits that would otherwise be paid by the Plan. To the extent that a Welfare Plan Document also contains provisions regarding coordination of benefits, this Section and the applicable provisions of such Welfare Plan Document shall both apply so as to grant the Plan the greatest possible rights.

2.11 Participant's Right to Recover Overpayments.

If a Participant overpays contributions or premiums for coverage under the Plan, the Plan will refund excess contributions or premiums upon request of the Participant to the extent administratively feasible.

2.12 Claims and Appeals Procedures.

Each claim for benefits under a Welfare Program must be filed in accordance with the procedures set forth in the applicable Welfare Program Documents. All claims for benefits must be duly filed no later than the deadline for such Welfare Program set forth in the applicable Welfare Program Documents. All claims for benefits will be processed and may be appealed in accordance with procedures of such Welfare Program as set forth in the Welfare Program Documents. To the extent that a Welfare Program Document provides for voluntary levels of appeal, the Plan agrees (a) to waive the right to assert that the Participant failed to exhaust their administrative remedies by not submitting the dispute to the voluntary level of appeal; (b) that the statute of limitations will be suspended during the time that such voluntary level of appeal is pending; and (c) that a Participant may elect to submit the benefit dispute to the voluntary level of appeal after exhaustion of the appeals permitted under Department of Labor regulations.

2.13 Limitations of Actions.

Participants must follow the claims procedures, including exhausting their rights to appeal, before taking action in any other forum regarding a claim for benefits under a Welfare Program. Unless otherwise specified in a Welfare Program Document, Participants will have a maximum period of the later of (a) 90 days immediately following a final external adverse benefit determination; and (b) 125 days immediately following a deemed exhaustion of administrative remedies or a final determination in which to file suit in court. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the claims procedures of the applicable Welfare Program Documents or herein. This limitation on suits for benefits applies in any forum where a Participant initiates a suit or legal action.

2.14 Right to Request Medical Records.

The Plan has the right to request medical, dental and vision records for any Participant, Dependent and Beneficiary.

2.15 Right to Audit.

The Plan has the right to audit Participant, Beneficiary and Dependent claims, including claims of medical providers. The Plan may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider, Participant, Dependent and Beneficiary based on the results of an audit.

2.16 Participant Rights Under ERISA.

Participants and Beneficiaries in the Plan are entitled to certain rights and protections under ERISA. ERISA provides that all Participants, Dependents and Beneficiaries shall be entitled to:

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

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

If applicable, receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

(b) **Continue Group Health Plan Coverage.** Under ERISA, Participants, Dependents and Beneficiaries are entitled to continue health care coverage for themselves if there is a loss of coverage under the Plan as a result of a qualifying event. They may have to pay for such coverage. For more information, please review Section V and the documents governing the Plan about the rules governing COBRA continuation coverage rights.

(c) **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Participants, Dependents and Beneficiaries, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants, Dependents and Beneficiaries. No one, including the Employer or any other person, may fire an Employee or otherwise discriminate against them in any way to prevent them from obtaining a Welfare Program benefit or exercising their rights under ERISA.

(d) **Enforcement of Rights.** If a claim for a Welfare Program benefit is denied or ignored, in whole or in part, Participants, Dependents and Beneficiaries have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps that can take to enforce the above rights. For instance, if a copy of a Welfare Program Document is requested or a request is made for the latest annual report from the Plan Administrator and are not received within 30 days, a suit may be filed in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant or Beneficiary up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the administrator.

If a Participant, Dependent or Beneficiary has a claim for benefits, which is denied or ignored in whole or in part, they may file suit in a state or federal court. In addition, if they disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, they may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if Participants, Dependents or Beneficiaries are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If they are successful, the court may order the person who has been sued to pay these costs and fees. If the Participant, Dependent or Beneficiary lose, the court may order them to pay these costs and fees, for example, if it finds that the claim is frivolous.

(e) **Assistance with Questions.** If a Participant, Dependent or Beneficiary has any questions about the Plan, they should contact the Plan Administrator. If they have any questions about this statement or their rights under ERISA, or if they need assistance in obtaining documents from the Plan Administrator, they should contact the nearest office of the U. S. Department of Labor, listed in the telephone directory or the Employee Benefits Security Administration, U. S. Department of Labor, Frances Perkins Building, 200 Constitution Ave., NW, Washington D.C., **www.dol.gov**, or telephone 1-866-444-3272. They may also obtain certain publications about their rights and responsibilities under ERISA by using this same contact information.

ARTICLE III.

ELIGIBILITY AND PARTICIPATION, TERMINATION AND LEAVES OF ABSENCE

3.1 Employee Eligibility.

In general, eligibility to participate in a Welfare Program shall be determined by the provisions of the applicable Welfare Program Documents.

3.2 Enrollment Procedures.

The Plan Administrator shall establish procedures for the enrollment of Participants in a Welfare Program. The Plan Administrator shall prescribe enrollment forms, which may include electronic equivalencies that must be completed by a prescribed deadline prior to commencement or continuation of coverage under a Welfare Program. In order to participate in the Plan, eligible Employees must submit the enrollment application, complete all forms, satisfy all conditions and be accepted by the Plan Administrator.

3.3 Automatic Re-Enrollment for Medical Benefits.

A Participant who is enrolled in a self-insured medical benefit option may be re-enrolled in the same medical benefit option for the subsequent Plan Year, unless the Participant affirmatively changes options or disenrolls during an enrollment period. If a Participant's medical plan option is no longer available, the Participant will be re-enrolled in the default medical benefit option as described in the applicable Welfare Program Document at the time.

3.4 Termination of Coverage.

(a) A Participant will cease being a Participant in a Welfare Program and coverage under such Welfare Program for the Participant and his Dependents and Beneficiaries shall terminate in accordance with the provisions of the applicable Welfare Program Document. COBRA continuation coverage or conversion to individual coverage, where applicable, may be available.

(b) If a Welfare Program is discontinued, coverage under the terminated Welfare Program will terminate on the effective date of termination.

(c) Coverage will also terminate retroactively under circumstances which constitute fraud upon the Plan or a material misrepresentation to the Plan. Under these circumstances, coverage will be rescinded to the date of fraud or material misrepresentation.

(d) Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Learn more about many of these options at www.healthcare.gov or contact KeenanDirect.com.

3.5 Leaves of Absence.

If a Participant commences an approved leave of absence that is not the subject of FMLA or State Mandated Leave, benefits may be continued during the period of the approved leave of absence subject to the terms and conditions of the Prime leave of absence polices hereby incorporated by reference.

3.6 Family and Medical Leave Act.

If the Participant commences an approved Leave of Absence under FMLA, coverage under the applicable Welfare Program will continue to be made available during the FMLA leave period to the Participant, Dependents and Beneficiaries under the same terms and conditions that coverage was made available immediately prior to the commencement of the Leave of Absence. Continuation of coverage may be available under other applicable Welfare Programs but Participants need to review the Welfare Program Documents as described in the Prime leave of absence polices hereby incorporated by reference.

3.7 Uniformed Services Leaves of Absence.

If a Participant commences a Leave of Absence under the Uniformed Services Employment and Reemployment Rights Act of 1994, ("USERRA"), the following provisions shall apply to applicable Welfare Program coverage provided under this Plan:

(a) In any case in which a Participant has coverage under a Welfare Program and is absent from employment by reason of service in the uniformed services, he may elect to continue applicable Welfare Program coverage as provided herein or as provided in the relevant Welfare Program Document.

(b) The maximum period of coverage that a Participant can elect is the lesser of: (a) the 24-month period beginning on the date on which the USERRA Leave of Absence begins; or (b) the period beginning on the date on which the USERRA Leave of Absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment.

(c) If a Participant elects to continue Plan coverage under USERRA, he may be required to pay not more than 102% of the full premium under the Plan (determined in the same manner as the applicable premium under COBRA with respect to other Employees), except that in the case service in the uniformed services is for less than 31 days, he will not be required to pay more than his share, if any, for coverage.

(d) Except as provided in paragraph (b), in the case coverage was terminated by reason of service in the uniformed services, an exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if an exclusion or waiting period would not have been imposed under the Welfare Program had coverage not been terminated as a result of uniformed service.

(e) Paragraph (a) shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

In cases where a Participant is eligible for COBRA coverage, USERRA leave will be an alternative to COBRA coverage and will run concurrently with the right to COBRA. In no event will USERRA coverage increase the duration of coverage eligibility for COBRA.

ARTICLE IV.

SPECIAL ENROLLMENT RIGHTS AND CHANGE IN STATUS

Elections made with respect to coverage under the Plan may not be changed during the Plan Year, and may only be changed during Open Enrollment, unless there is a special enrollment right or other circumstance which is permitted by the Plan, a Welfare Program Document or the Cafeteria Plan.

4.1 Special Enrollment Rights.

A Special Enrollment Right allows enrollment in the Plan during the Plan Year under certain conditions.

(a) If enrollment was declined by the Participant for himself, Dependents or Beneficiaries (including a spouse) because of other health insurance coverage, the Participant will be able to enroll himself, Dependents or Beneficiaries, as applicable, in the Plan, provided that the enrollment application is submitted within 30 days after the other health insurance coverage ends.

(b) If there are new Dependents or Beneficiaries as a result of marriage, birth, adoption or placement for adoption, a Participant may be able to enroll himself, Dependents or Beneficiaries into the Plan, provided that the enrollment forms are submitted within 30 days after the marriage, birth, adoption or placement for adoption.

(c) If a Participant, Dependent or Beneficiary's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility, enrollment forms must be submitted within 60 days after the termination; or

(d) If a Participant, Dependent or Beneficiary become eligible for a contribution/premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), enrollment forms must be submitted within 60 days after eligibility is determined.

For more information on Special Enrollment Rights, please see the Welfare Program Documents.

4.2 Change in Status.

A Change in Status may allow enrollment, cancelation of coverage or changes in the amount of Participant Contributions. However, the change is being requested must be consistent with, on account of, and correspond to the event.

(a) A Change in Status would include a change in the number of Dependents or Beneficiaries due to marriage, change in registered domestic partner status, divorce, legal separation, and annulment, death of a dependent or birth of one. The special enrollment rights described above would be considered change in status events.

(b) A change in employment status for an Employee, Dependent or Beneficiary which results in a loss or gain of eligibility for coverage under the Plan or another employer's plan would be a Change in Status. Commencement of employment, termination of

employment, commencement or return from an unpaid Leave of Absence, or change in work schedules (full-time to part-time) are examples of Change in Status events.

For more information about Change in Status events, please refer to the Cafeteria Plan document and Welfare Program Documents.

4.3 The Plan Administrator Must Approve an Election Change.

A Special Enrollment Right or Change in Status event does not mean that an election can be changed automatically. Because of Code requirements, the Plan Administrator must determine whether an election change request, based on IRS rules, may be changed during the Plan Year.

4.4 Effective Date of New Elections.

If a new election satisfies the rules of the Plan, the Welfare Program Documents and Cafeteria Plan, and is approved by the Plan Administrator, the effective date of the new election will determine the effective date of the change. Please review the relevant Welfare Program Documents.

ARTICLE V.

COBRA CONTINUATION COVERAGE

The Plan includes a continuation of coverage option, which is available to Participants, Dependents and Beneficiaries whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with COBRA, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail. This Part V is not intended to impose COBRA obligations on fully-insured Welfare Programs subject to COBRA or similar state law. Those Welfare Program Documents will describe COBRA rights and rights to continuation of coverage under state law, if applicable.

Life insurance, accidental death and dismemberment, disability benefits, health savings accounts and other non-health plans are not eligible for continuation under COBRA.

If there is a covered Dependent or Beneficiary whose legal residence is not the Participant's, please provide that individual's name and address to the Plan Administrator so a notice about COBRA can be sent to that Dependent or Beneficiary as well.

COBRA requires the Employer to offer Participants, Dependents and Beneficiaries the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This Section is intended to inform Participants, Dependents and Beneficiaries, if any, of potential future options and obligations under the Continuation Coverage provisions of COBRA. Welfare Program Documents should be reviewed for COBRA information.

Should an actual qualifying event occur in the future, the Participant is required to notify the Plan Administrator and Employer within 30 days of the event in which case the Plan Administrator will send additional information and the appropriate election notice at that time.

The information described in this Section replaces any discussion of COBRA continuation coverage contained in the insurance certificate or benefit booklet and is only intended to provide COBRA continuation coverage to the extent required by law; provided however that if the Plan provides coverage for domestic partners, COBRA Continuation Coverage will be provided to the extent provided under the terms in the insurance certificate or benefit booklet.

The Trade Act of 2002 creates a special second 60-day election period for certain workers who did not elect COBRA coverage during the Plan's regular election period. (This special second election period is available only in limited circumstances for certain individuals who have been affected by foreign competition and who are receiving trade adjustment assistance or alternative trade adjustment assistance under the Trade Act of 1974.)

5.1 Qualifying Events for the Participant.

A Participant may have the right to elect COBRA for any of the following events which would result in the loss of group health coverage under the Plan:

(a) Voluntary or involuntary termination of employment for any reason (other than for gross misconduct) or a reduction in a Participant's hours of service of employment to

non-eligible status (including an absence from work due to disability, temporary layoff or Leave of Absence) where Plan coverage terminates;

(b) Failure to return to work at the expiration of FMLA leave, even if there is a failure to pay Participant Contributions during the FMLA leave.

5.2 Qualifying Events for a Covered Spouse.

A spouse covered under the Plan may have the right to elect COBRA continuation coverage if there is a loss of Welfare Program coverage under the Plan because of any of the following reasons:

(a) A termination of the Participant's employment (for reasons other than gross misconduct) or reduction in hours of service of employment of the Participant;

(b) Death of the Participant;

(c) Divorce, annulment or legal separation from the Participant; or

(d) The Participant becomes entitled to Medicare.

5.3 Qualifying Events for Other Dependents and Beneficiaries.

A Dependent or Beneficiary other than a spouse may have the right to elect COBRA continuation coverage if there is a loss of group health coverage under the Plan because of any of the following reasons:

(a) A termination of the Participant's employment (for reasons other than gross misconduct) or a reduction in his hours of service of employment;

(b) The loss of Dependent status under the Plan (e.g., attainment of the Plan's maximum age limit);

(c) The death of the Participant;

(d) Divorce, annulment or legal separation of the Participant; or

(e) The Participant's entitlement to Medicare.

5.4 Important Notice to Participants, Dependents and Beneficiaries.

You have the responsibility to notify the Plan Administrator of any of the events described above. This notification must be made within 60 days after the later of the date on which the qualifying event occurs or the date on which there is a loss or would lose coverage as a result of the qualifying event. You must provide this notice by mail or personal delivery to the Plan Administrator.

This notice must identify: (a) the individuals who are impacted ("qualified beneficiaries") and their respective addresses, phone numbers and dates of birth, (b) the qualifying event, (c) the date the qualifying event occurred, (d) include evidence supporting the occurrence of the qualifying event acceptable to the Plan Administrator or its designee; and (e) the name of the

Welfare Program under which coverage is being lost and the level of coverage at the time of the event. For example, in the case of a Social Security Disability, the notice must include a copy of the Social Security Administrator's determination of disability.

If notification is not completed according to the Plan Administrator's procedures and within the required 60-day notification period, then rights to COBRA continuation coverage will be forfeited. Carefully read the applicable Dependent and Beneficiary eligibility rules so you are familiar with when a Dependent or Beneficiary ceases to be a covered under the terms of the applicable Welfare Program.

5.5 Electing COBRA Coverage following Notification.

The Plan Administrator must provide covered individuals ("qualified beneficiaries") with notification of their COBRA continuation coverage rights. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect COBRA continuation coverage. The 60-day election window is measured from the later of the date of COBRA notification on or after the qualifying event or the date coverage is lost. This is the maximum period allowed to elect COBRA. If a qualified beneficiary does not elect Continuation Coverage within this election period, then rights to continue coverage under the applicable Welfare Program will end and he ceases to be a qualified beneficiary.

To elect COBRA continuation coverage, you must complete the applicable election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. COBRA may be elected for only one, several, or for all Dependents and Beneficiaries who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any covered children. The Participant or his spouse can elect COBRA on behalf of all qualified beneficiaries.

Please consider your right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends under the Plan because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you have COBRA coverage for the maximum time available to you.

If, during the 60-day election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date that they are sent to the Plan Administrator or its designee for COBRA administration.

5.6 Effective Date of Coverage.

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for coverage in this retroactive period. There is an exception to the above when a qualified beneficiary initially waives

COBRA continuation coverage and then revokes his waiver as described above. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

5.7 Coverage and Cost of COBRA Benefits.

The Employer is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA covered individuals. Should coverage change or be modified for non-COBRA covered individuals, then the change and/or modification will be made to your coverage as well.

If a qualified beneficiary elects COBRA, he will be required to pay the entire cost for the coverage, plus a 2% administration fee. Note that the cost for COBRA continuation coverage provided during a disability extension will increase to 150%. If you elect COBRA, you must make your first payment for coverage not later than 45 days after the date of your election. If you fail to make your first payment in full before the end of the 45-day period following the date of your election, you will lose all continuation coverage rights under the Plan and COBRA.

After you make your first payment for coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, each of these periodic payments for coverage is due on the first day of the coverage period. However, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your coverage will be continued for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to coverage under the Plan and COBRA.

5.8 Maximum Coverage Period.

(a) 18 months from the date of the qualifying event for a voluntary or involuntary termination of employment or reduction of hours of service of employment (See Disability Extension below);

(b) 36 months from the date of the qualifying event for a Participant's loss of coverage under the Plan due to entitlement in the Medicare program;

(c) For any other qualifying event, the maximum coverage period ends 36 months after the qualifying event.

If a qualifying event which provides an 18-month or 29-month maximum coverage period is followed by a second qualifying event that allows a 36-month maximum coverage period, the coverage period will be expanded to 36 months, but only for individuals who are qualified beneficiaries at the time of both qualifying events. Thus, a termination of employment following a qualifying event that is a reduction of hours of service of employment or a bankruptcy of the Plan Sponsor following any qualifying event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first qualifying event.

Medical continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) does not extend the COBRA continuation period but any such Participant and any of his Dependents and Beneficiaries shall be treated as any other qualified beneficiary for purposes of COBRA.

5.9 Disability Extension.

An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a qualified beneficiary is determined under Title II or XVIII of the Social Security Act to have been disabled at the time of the qualifying event or at any time during the first 60 days thereafter. To qualify for the disability extension, the Plan Administrator or its designee must be provided with notice of the Social Security Administration's disability determination date no later than 60 days after the latest of: (a) the date of the Social Security Administration's disability determination; (b) the date the qualifying event occurred; (c) the date the qualified beneficiary loses coverage; or (d) the date the qualified beneficiary is informed of the obligation to provide the disability notice. The qualified beneficiary must also be disabled at the end of the 18-month period to be eligible for the 11-month extension. The disabled qualified beneficiary or any qualified beneficiaries in his family may notify the Plan Administrator of the determination. The Plan must also be notified if the qualified beneficiary is later determined by the Social Security Administration to be no longer disabled and a copy of the Social Security Administration notice must be provided to the Plan Administrator or its designee. The notification must be provided no later than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled.

Under the Disability extension, the qualified beneficiary's cost for continuation coverage for the 19th through 29th month of continued coverage shall increase to 150% of the Plan's cost for similarly situated Non-COBRA beneficiaries.

If the individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period.

5.10 Early Termination of Continuation Coverage.

Except for an initial interruption of Plan coverage in connection with a waiver, COBRA continuation coverage that has been elected by or for a qualified beneficiary will extend for the periods described above and end on the earliest of the following dates:

(a) The date on which the Plan Sponsor ceases to provide any group health plan to any Employee;

(b) The date, after the date of the COBRA election, that the qualified beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition pertaining to the qualified beneficiary;

(c) The date, after the date of the COBRA election, that the qualified beneficiary first becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his Medicare coverage is in effect;

(d) In the case of a qualified beneficiary entitled to a disability extension, the later of (a) 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination that the individual is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension;

(e) The end of the last period for which the cost of continuation coverage is paid timely;

(f) Notification to the Plan Administrator or its designee by a qualified beneficiary; or

(g) For cause, on the same basis that the Plan terminates the coverage of similarly situated non-COBRA participants.

5.11 Notification of Address Change.

To ensure all covered individuals receive information properly and efficiently, it is important that you notify the Plan Administrator and its designee of any address change as soon as possible. Your failure to do so may result in delayed COBRA notifications or a loss of continuation coverage options.

5.12 Eligibility and Potential Conversion Rights.

A qualified beneficiary does not have to show insurability to elect COBRA continuation coverage; however, he must have been actually covered by the Plan on the day before the qualifying event to be eligible for COBRA. An exception to this rule is if while on COBRA continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the Plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Contact the Plan Administrator for the procedures and timelines for adding these individuals. The Plan Administrator reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

At the end of the 18, 29, or 36 months of COBRA continuation coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under the group health plan if an individual conversion plan is available at that time.

5.13 Health Flexible Spending Arrangement.

COBRA continuation coverage under the Plan will be made available when coverage would otherwise end because of a qualifying event described above provided that Employee was a Participant in the Plan, and the remaining balance in his account available for reimbursement exceeds the amount of premium payments he or she would be required to make to such account for the remainder of the Plan Year in which the qualifying event occurred.

Note, however, that upon the occurrence of a qualifying event where the above conditions are satisfied, a qualified beneficiary may not establish a new account under the Plan under COBRA. Instead, a qualified beneficiary may only elect COBRA continuation coverage in the account originally established by the covered Employee.

Notwithstanding anything contained in this notice, COBRA continuation coverage under the Plan may not continue beyond the end of the Plan Year in which the qualifying event occurred.

5.14 Assistance from the Federal Government.

Questions concerning the Plan or COBRA continuation coverage can be addressed by the Plan Sponsor and Plan Administrator in accordance with this Wrap Document. For more information about the rights under the Employee Retirement Security Act (ERISA) of 1974, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, all affected parties can contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa.

ARTICLE VI.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

ERISA requires that, as part of a divorce action, a court, domestic relations magistrate or administrator can enter an order referred to as a Medical Child Support Order (MCSO) which grants a child the right to receive health benefits under one of his parent's group health plans, regardless of whether the parent is the custodial parent of the child. However, to be valid or "qualified" (QMCSO), it must satisfy certain statutory requirements which are identified below or as required by the Welfare Program Documents.

6.1 QMCSO Procedures.

Upon receipt of a notice of a MCSO and request for coverage under the group health plan for one or more children of an Employee or covered spouse or registered domestic partner, the following will occur:

(a) The Plan Administrator will send a letter acknowledging receipt of the MCSO. The letter will be sent to the Employee and to each affected child;

(b) The Plan Administrator will review the MCSO to make certain that:

(i) It is issued pursuant to a valid state domestic relations law;

(ii) It provides, specifically, for a child to receive benefits under the group health coverage(s);

(iii) The name and last known mailing address of the Employee and each child covered by the MCSO is included;

(iv) It includes a reasonable description of the coverage to be provided by the Plan or the manner in which the coverage can be determined. The MCSO cannot require a Plan to provide any benefit or option that is not otherwise provided;

1) The time period to which the Order applies is expressly described; and

2) Identifies each group health benefit to which the MCSO applies.

The Employee may be required to provide necessary identifying information about the affected children, such as Social Security numbers, so that the Plan Administrator can comply with the requirements of the law.

(c) Upon completion of its review, the Plan Administrator will send a letter to the Employee and each affected child advising whether or not the order is a QMCSO.

If determined to be a QMCSO, each child affected is entitled to all reporting and disclosure requirements to which other Dependents and Beneficiaries are entitled under ERISA. Any child affected by the QMCSO is also permitted to designate a representative to receive copies of any notices regarding this matter or any coverage or benefits matters. Any such designation should be sent to the Plan Administrator.

ARTICLE VII.
ADMINISTRATION AND FIDUCIARY PROVISIONS

7.1 Administrator.

The Committee shall be the Administrator and the "named fiduciary" of the Plan, as defined in ERISA Section 402(a)(2).

Except where responsibilities have been assigned to the Third-Party Administrator, insurer or another fiduciary, the Committee shall have the general responsibility for the administration of the Plan and for carrying out its provisions as follows:

(a) The Committee shall have the discretion and authority to control and manage the operation and administration of the Plan.

(b) The Committee shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Committee made pursuant to the Plan shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Committee shall have all other duties and powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To communicate the terms of the Plan to Employees, Dependents, Participants, and Beneficiaries;

(ii) To prescribe procedures and related forms (which may be electronic in nature) to be followed by Participants, Dependents and Beneficiaries, including forms and procedures for making elections and contributions under the Plan;

(iii) To receive from Participants, Dependents, and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records related to the Plan, including any other information required by ERISA or the Code;

(v) To appoint, discharge and periodically monitor the performance of Third-Party Administrators, insurers, service providers and other agents in the administration of the Plan;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(viii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan;

(ix) To issue rules and regulations necessary for the proper conduct and administration of the Plan and to change, alter, or amend such rules and regulations;

(x) To determine all questions arising in the administration of the Plan, to the extent the determination is not the responsibility of a Third-Party Administrator, insurer or some other entity;

(xi) To propose and accept settlements of claims involving the Plan, including claims for benefits;

(xii) To direct the Third-Party Administrator, insurer, or some other entity to pay benefits and Plan expenses properly chargeable to the Plan; and

(xiii) Such other duties or powers provided in the Plan.

(d) The Committee shall have exclusive authority and discretion to manage and control the assets of the Plan.

(e) Except as expressly provided in the Plan, the Committee shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, supply omissions, with respect to determining the benefits payable and eligibility for benefits under the Plan. All decisions and interpretations of the Committee pursuant to the Plan shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Committee shall have the powers necessary or desirable to carry out these responsibilities, including, but not limited to, the following:

(i) To prescribe procedures and related forms (which may be electronic in nature) to be followed by Participants filing claims for benefits under the Plan;

(ii) To receive from Participants, Dependents, and Beneficiaries such information as shall be necessary for the proper determination of benefits payable under the Plan;

(iii) To keep records related to claims for benefits filed and paid under the Plan;

(iv) To determine and enforce any limits on benefit elections hereunder;

(v) To correct errors and make equitable adjustments for mistakes made in the payment or nonpayment of benefits under the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, Dependent or Beneficiary, in whatever manner the Committee deems appropriate, including suspensions or recoupments of, or offsets against, future payments, including benefit payments due that Participant, Dependent or Beneficiary;

(vi) To determine questions relating to coverage and participation under the Plan and the rights of Participants to the extent the determination is not the responsibility of a Third-Party Administrator, insurer or some other entity;

(vii) To propose and accept settlements and offsets of claims, overpayments and other disputes involving claims for benefits under the Plan; and

(viii) To compute the amount and kind of benefits payable to Participants, Dependents and Beneficiaries, to the extent such determination is not the responsibility of a Third-Party Administrator, insurer, or some other entity.

The Committee shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a Third-Party Administrator, insurer or other fiduciary where such person has been selected by the Committee to make such determinations. In such case, such other person shall have the duties and powers as the Committee as set forth above, including the complete discretion to interpret and construe the provisions of the Plan.

(f) Notwithstanding any other provision of this Wrap Document, the Committee shall have the discretion and authority to carry out any duty or function that is necessary or desirable to administer the Plan that either is not clearly allocated to the or another Plan fiduciary, or, at its discretion, is otherwise allocated to another Plan fiduciary.

7.2 Allocation and Delegation of Duties.

(a) The Committee shall have the authority to allocate, from time-to-time, all or any part of its responsibilities under the Plan to one or more of its members, including a subcommittee, as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the member or subcommittee to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Committee. The Committee shall not be liable for any acts or omissions of such member or subcommittee.

(b) The Committee shall have the authority to delegate, from time-to-time, all or any part of its responsibilities under the Plan to such person or persons as the Committee may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Committee shall authorize) and in the same manner to revoke any such delegation of responsibilities. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Committee. The Committee shall not be liable for any acts or omissions of any such delegate.

7.3 Indemnification.

To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the members of the Committee, officers and Employees of the Plan Sponsor who provide services to the Plan shall be indemnified by the Plan Sponsor against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (a) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful

misconduct, or (b) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

7.4 Bonding.

The members of the Committee shall serve without bond (except as otherwise required by section 412 of ERISA) and without additional compensation for their services.

7.5 Plan Expenses.

All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, Committee, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid.

7.6 Information to be Supplied by Employer.

The Employer shall provide the Committee or its delegates with such information as they shall from time-to-time need or reasonably request in the discharge of its duties. The Committee may rely conclusively on the information provided by the Employer.

ARTICLE VIII.

HIPAA STANDARDS FOR PRIVACY PROVISIONS

The provisions of this Section are effective in order to comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

8.1 Definitions.

(a) "Business Associate" means

(i) A person who, on behalf of the Plan: 1) performs a function that involves the use or disclosure of Protected Health Information, including claims processing, data analysis, utilization review, quality assurance, patient safety activities listed at 42 C.F.R. § 3.20, billing, benefit management, practice management, and repricing; or 2) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services that involve the disclosure of Protected Health Information from the Plan, or from another Business Associate of the Plan, to the person.

(ii) Business Associate includes 1) a health information organization, e-prescribing gateway, or other person that provides data transmission services with respect to Protected Health Information to the Plan and that requires access on a routine basis to such Protected Health Information; 2) a person that offers a personal health record to one or more individuals on behalf of the Plan; 3) patient safety organizations; and 4) a subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the Business Associate.

(iii) However, Business Associate does not include 1) a health care provider, with respect to disclosures by a Plan to the health care provider concerning the treatment of the individual; 2) the Plan sponsor, with respect to disclosures by the Plan to the Plan sponsor, to the extent that the requirements of Section (8.1) apply and are met; 3) a government agency, with respect to determining eligibility for, or enrollment in, a government health plan that provides public benefits and is administered by another government agency, or collecting Protected Health Information for such purposes, to the extent such activities are authorized by law; or 4) a Covered Entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (a)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (a)(ii) of this definition to or for such organized health care arrangement by virtue of such activities or services.

(b) "Breach"

(i) Breach means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under this Article or the HHS regulations which compromises the security of privacy of the protected health information.

(ii) The term "Breach" does not include any of the following:

1) Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of the Plan, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HHS Regulations.

2) Any inadvertent disclosure by a person who is authorized to access Protected Health Information at the Plan to another person authorized to access Protected Health Information at the Plan, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HHS Regulations.

3) A disclosure of Protected Health Information where the Plan has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(c) "Health Information" means any information, including genetic information, whether oral or recorded, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual.

(d) "Health Care Operations" means any of the following activities of the Plan: (i) conducting quality assessment and improvement activities; (ii) reviewing the competence or qualifications of health care providers; (iii) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits (including stop-loss insurance); (iv) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (v) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan; and (vi) business management and general administrative activities of the Plan, including compliance with the requirements of this Section, and the provision of data analyses for the Sponsoring Employer. However, the Plan will not use your genetic information for underwriting purposes.

(e) "HHS Regulations" means those regulations regarding security and privacy of Protected Health Information, as set forth in 45 CFR Subtitle A, Subchapter C, as amended from time to time, and any subsequent laws and regulations relating to such subject matter.

(f) "Individually Identifiable Health Information" means Health Information that either identifies the individual or provides a reasonable basis to believe it can be used to identify the individual.

(g) "Limited Data Set" means Protected Health Information that excludes the direct identifiers of the individual or of relatives, employers, or household members of the individual.

(h) "Payment" means the activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the

Plan, or to obtain or provide reimbursement for the provision of health care, including: (i) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; (ii) billing, claims management, collection activities, and obtaining payment under a contract for reinsurance; (iii) review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, or justification of charges; (iv) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (v) disclosure to consumer reporting agencies of Protected Health Information relating to collection of premiums or reimbursement.

(i) "Protected Health Information" means Individually Identifiable Health Information other than employment records held by the Plan in its role as employer, education records covered by the Family Educational Rights and Privacy Act, as amended (20 U.S.C. § 1232g), records described at 20 U.S.C. § 1232g (a) (4) (B) (iv), and information regarding a person who has been deceased for more than 50 years.

(j) "Summary Health Information" means information, which may be Individually Identifiable Health Information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Sponsoring Employer has provided health benefits under the Plan, but excludes the identifying information described at HHS Regulations Section 164.514(b)(2)(i).

(k) "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a Third-Party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

(l) "Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified on the Department of Health and Human Services Web site.

8.2 Disclosures to Business Associates.

(a) The Plan may disclose Protected Health Information to a Business Associate and may allow a Business Associate to create, receive, maintain, or transmit electronic Protected Health Information on its behalf, only if the Plan obtains satisfactory assurances, in accordance with provisions of this Article that the Business Associate will appropriately safeguard the information.

(b) There shall be a contract between the Plan and a Business Associate. Such contract must:

(i) Establish the permitted and required uses and disclosures of Protected Health Information by the Business Associate. The contract may not authorize the Business Associate to use or further disclose the information in a manner that would violate the requirements of subpart E of the HHS Regulations (45 C.F.R.

§§ 164.500 to 164.534) if done by the Plan, except that: 1) the contract may permit the Business Associate to use and disclose Protected Health Information for the proper management and administration of the Business Associate; and 2) the contract may permit the Business Associate to provide data aggregation services relating to the Health Care Operations of the Covered Entity.

(ii) Provide that the Business Associate will:

1) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

2) With respect to electronic Protected Health Information: (x) comply with the applicable requirements of 45 C.F.R. §§ 164.302 to 164.318 (including security standards, administrative safeguards, physical safeguards, technical safeguards, organizational requirements, and policies and procedures and documentation requirements); (y) ensure that any subcontractors that create, receive, maintain, or transmit electronic Protected Health Information on behalf of the Business Associate agree to comply with the applicable requirements of 45 C.F.R. §§ 164.302 to 164.318 by entering into an appropriate contract or other arrangement; and (z) report to the Plan any security incident of which it becomes aware, including Breaches of unsecured Protected Health Information as required by 45 C.F.R. § 164.410;

3) Report to the Plan any use or disclosure of the information not provided for by its contract of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. § 164.410;

4) Ensure that any subcontractors that create or receive Protected Health Information on behalf of the Business Associate agree to the same restrictions and conditions that apply to the Business Associate with respect to such information in accordance with 45 C.F.R. § 164.502(e)(1)(ii);

5) Make available Protected Health Information in accordance with 45 C.F.R. § 164.524;

6) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

7) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

8) To the extent the Business Associate is to carry out the Plan's obligation under subpart E of the HHS Regulations (45 C.F.R. §§ 164.500 to 164.534), comply with the requirements of subpart E of the HHS Regulations that apply to the Plan in the performance of such obligation;

9) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Plan available to the

Secretary of Health and Human Services for purposes of determining the Plan's compliance with subpart E of the HHS Regulations (45 C.F.R. §§ 164.500 to 164.534); and

10) At termination of the contract, if feasible, return or destroy all Protected Health Information received from, or created or received by the Business Associate on behalf of, the Plan that the Business Associate still maintain in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(iii) Authorize termination of the contract by the Plan, if the Plan determines that the Business Associate has violated a material term of the contract.

If the Plan knows of a pattern of activity or practice of the Business Associate that constituted a material breach or violation of the Business Associate's obligation under the contract or other arrangement, the Plan shall take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful, terminated the contract or arrangement, if feasible.

(iv) Notwithstanding the above, the Plan is deemed to be in compliance with the documentation and contract requirements with respect to a particular Business Associate relationship until the earlier of:

1) The date such contract or other arrangement is renewed or modified on or after the date that is 240 days after the date of publication of final regulations ("Publication Date"); or

2) The date that is one year and 240 days after the Publication Date if the following conditions are satisfied:

a) Prior to the Publication Date, the Plan has entered into and is operating pursuant to a written contract or other written arrangement with the Business Associate that complies with the applicable provisions of HHS regulations Section 164.314(a) or 164.504(e) that were in effect on such date; and

b) The contract or other arrangement is not renewed or modified from 60 days after the Publication Date until 240 days after the Publication Date.

8.3 Disclosures to Plan Sponsor.

(a) Subject to paragraph (2) below, the Plan may disclose the following to the Plan Sponsor:

(i) Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan;

(ii) Information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or offered by the Plan; and

(iii) Information in accordance with an authorization described below.

(b) The Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan documents incorporate the following provisions and that the Plan Sponsor agrees to:

(i) Not use or further disclose the information other than as permitted or required by the Plan documents;

(ii) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(v) Make available Protected Health Information in accordance with the Access, Amendment and Accounting provisions described below;

(vi) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HHS Regulations;

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

(viii) (Ensure that the adequate separation required below in paragraph (c) is established.

(c) There shall be adequate separation between the Plan and the Plan Sponsor. Those persons under the control of the Plan Sponsor to be given access to Protected Health Information shall be shall be set forth in the Plan's written policies or procedures. In the event no such persons are identified in such policies or procedures, such persons shall consist of the employees of the Plan Sponsor's Human Resources Department, and any other person who receives Protected Health Information relating to Payment under, Health Care Operation of, or other matters pertaining to the Plan in the ordinary course of business. The access to and use of Protected Health Information by such persons shall be restricted to the Plan administration functions that the Plan Sponsor performs

for the Plan. The Plan Sponsor will provide an effective mechanism for resolving any noncompliance with the terms of this paragraph.

8.4 Disclosures for Treatment, Payment, or Health Care Operations.

Except with respect to uses or disclosures that require an authorization as described below, the Plan may use or disclose Protected Health Information: (i) for the Plan's Payment or Health Care Operations; (ii) for Treatment activities of a health care provider; (iii) to another Covered Entity or a health care provider for the Payment activities of the entity that receives the information; or (iv) to another Covered Entity for Health Care Operations activities of the entity that receives the information if the disclosure is for health care fraud and abuse detection or compliance or for assessment or review of health care providers.

8.5 Disclosures Requiring an Authorization.

(a) Except as otherwise permitted or required by this Section, the Plan may not use or disclose Protected Health Information without an authorization that is valid under the disclosure provisions described herein.

(b) The Plan must obtain an authorization for any use or disclosure of (i) psychotherapy notes (except to the extent set forth in HHS Regulation Section 164.508(a)(2)), or (ii) Protected Health Information for marketing (except to the extent set for in HHS Regulation Section 164.508(a)(3)). The Plan must obtain an authorization for any disclosure of Protected Health Information for which the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the Protected Health Information (except to the extent set forth in HHS Regulation Section 164.508(a)(4)).

(c) The Plan will not use or disclose Protected Health Information for marketing and will not sell Protected Health Information without a written authorization.

(d) A written authorization is also required for any other use or disclosure not described in this Section.

(e) A valid authorization under this provision must contain at least the following elements: (i) a specific and meaningful description of the information to be used or disclosed; (ii) the identification of the persons authorized to make the requested use or disclosure; (iii) the identification of the persons to whom the Plan may make the requested use or disclosure; (iv) a description of each purpose of the requested use or disclosure; (v) an expiration date or an expiration event for the use or disclosure; and (vi) signature of the individual, date and, if applicable, title. An authorization for use or disclosure of Protected Health Information may not be combined with any other document to create a compound authorization (except to the extent set for in HHS Regulation Section 164.508(b) (3)).

(f) The authorization must contain statements adequate to place the individual on notice of all of the following: (i) the individual's right to revoke the authorization in writing, and the exceptions to the right to revoke; (ii) whether Treatment, Payment, enrollment or eligibility for benefits is conditioned on the individual signing the authorization; and

(iii) the potential for the information disclosed to be subject to redisclosure by the recipient.

8.6 Disclosures Allowing Individual to Agree or Object.

The Plan may use or disclose Protected Health Information for the reasons listed below, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. The Plan may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this paragraph.

(a) The Plan may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the Protected Health Information directly relevant to such person's involvement with the individual's care or Payment related to the individual's health care.

(b) The Plan may use or disclose Protected Health Information to notify or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death.

If the individual is deceased, the Plan may disclose Protected Health Information of the individual to a family member, other relative, a close personal friend of the individual, or any other person identified by the individual who was involved in the individual's care or payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Plan.

8.7 Disclosures Not Requiring Authorization or Agreement.

The Plan may use or disclose Protected Health Information without the written authorization of the individual or the opportunity for the individual to agree or object, in the following situations, subject to the applicable requirements of HHS Regulations § 164.512: (i) as required by law; (ii) for public health activities; (iii) regarding victims of abuse, neglect or domestic violence; (iv) for health oversight activities; (v) for judicial and administrative proceedings; (vi) for law enforcement purposes; (vii) regarding decedents; (viii) for cadaveric organ, eye or tissue donation purposes; (ix) for research purposes; (x) to avert a serious threat to health or safety; (xi) for specialized government functions; or (xii) for workers' compensation.

8.8 Other Requirements.

(a) When using or disclosing Protected Health Information or when requesting Protected Health Information from another Covered Entity, the Plan must make reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, except with respect to: (i) disclosures to or requests by a health care provider for Treatment; (ii) uses or disclosures made to the individual to which they relate; (iii) uses or disclosures made pursuant to an authorization under the Disclosure provisions above and (iv) uses and disclosures that are required by law.

(b) The Plan must identify: (i) those persons in its workforce who need access to Protected Health Information to carry out their duties; and (ii) for each such person, the categories of Protected Health Information to which access is needed and any conditions appropriate to such access. The Plan must make reasonable efforts to limit access to Protected Health Information consistent with the preceding sentence.

(c) The Plan may use or disclose a Limited Data Set only for the purposes of research, public health, or Health Care Operations. The Plan may use or disclose a Limited Data Set only if the Plan obtains satisfactory assurance, in the form of a data use agreement that meets the requirements of HHS Regulation Section 164.514(e)(4), that the Limited Data Set recipient will only use or disclose the Protected Health Information for limited purposes. If the Plan knows of a pattern of activity or practice of the Limited Data Set recipient that constitutes a material breach or violation of the data use agreement, the Plan must take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps are unsuccessful: (i) discontinue disclosure of Protected Health Information to the recipient; and (ii) report the problem to the Secretary of Health and Human Services.

8.9 Notice of Privacy Practices.

The Notice of Privacy Practices is attached as Appendix B.

8.10 Access of Individuals to Protected Health Information.

(a) Except as otherwise provided in HHS Regulation § 164.524, an individual has a right of access to inspect and obtain a copy of Protected Health Information about the individual. The Plan must act on a request for access no later than 30 days after receipt of the request (60 days if the Protected Health Information is not accessible to the Plan on-site). The Plan may extend the time for such actions by no more than 30 days, provided that the Plan, within the time limit set forth above, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request. If the individual requests a copy of the Protected Health Information, the Plan may impose a reasonable, cost-base fee.

(b) If the Plan denies access, in whole or in part, to Protected Health Information, the Plan must provide a timely, written denial to the individual in plain language that explains: (i) the basis for the denial; (ii) if applicable, a statement of the individual's review rights; and (iii) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services.

(c) If the individual has requested a review of a denial that is subject to review under HHS Regulation Section 164.524, the Plan must promptly refer the request to a licensed health care professional, who was not directly involved in the denial, to review the decision to deny access. The designated reviewing official must determine, with a reasonable period of time, whether or not to deny the access requested. The Plan must promptly provide written notice to the individual of the determination of the designated reviewing official.

8.11 Amendment of Protected Health Information.

(a) An individual may submit a written request that the Plan amend the Protected Health Information maintained by the Plan. The Plan must act on the individual's request no later than 60 days after receipt of the request. If the Plan is unable to act on the request within such 60-day period, the Plan may extend the time for such action by no more than 30 days, provided that the Plan, within such 60-day period, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request.

(b) If the Plan accepts the requested amendment, in whole or in part, the Plan must timely inform the individual that the amendment is accepted and obtain the individual's identification and agreement to have the Plan notify the relevant persons with whom the amendment needs to be shared. The Plan must make reasonable efforts to inform and provide the amendment within a reasonable period of time to: (i) persons identified by the individual as having received Protected Health Information needing the amendment; and (ii) persons, including Business Associates, that the Plan knows have the Protected Health Information and that may have relied, or could foreseeably rely, on such information to the detriment of the individual.

(c) If the Plan denies the requested amendment, in whole or in part, the Plan must provide the individual with a timely, written denial that explains: (i) the basis for the denial; (ii) the individual's right to submit a written statement disagreeing with the denial; (iii) a statement that, if the individual does not submit a statement of disagreement, the individual may request that the Plan provide the individual's request for amendment and the denial with any future disclosures of the Protected Health Information; and (iv) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services. The Plan may prepare a written rebuttal to the individual's statement of disagreement. Whenever such a rebuttal is prepared, the Plan must provide a copy to the individual who submitted the statement of disagreement. The Plan must, as appropriate, identify the Protected Health Information that is the subject of the disputed amendment and append or otherwise link the individual's request for an amendment, the Plan's denial of the request, the individual's statement of disagreement, if any, and the Plan's rebuttal, if any, to the information. The Plan must include such material, or an accurate summary, with any subsequent disclosure of the Protected Health Information to which the disagreement relates.

8.12 Accounting of Disclosures.

(a) An individual has a right to receive an accounting of disclosures of Protected Health Information made by the Plan in the six years prior to the date on which the accounting is requested, except for disclosures: (i) to carry out Treatment, Payment and Health Care Operations as provided above; (ii) to the individual; (iii) pursuant to an authorization described above; (iv) to persons involved in the individual's care or for other notification purposes as provided above; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; (vii) as part of a Limited Data Set as provided above; or (viii) that occurred prior to April 14, 2003.

(b) The Plan must provide an individual who submits a request for an accounting with a written accounting of disclosures by the Plan or Business Associates of the Plan that includes the following for each disclosure: (i) the date of the disclosure; (ii) the name of the person who received the Protected Health Information and, if known, the address of such person; (iii) a brief description of the Protected Health Information disclosed; and (iv) a brief statement of the purpose of the disclosure.

(c) The Plan must act on the individual's request for an accounting within the time limits described above. The Plan must provide the first accounting to an individual in any 12-month period without charge. The Plan may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12-month period, provided that the Plan informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

8.13 Administrative Requirements.

(a) The Plan must designate a privacy official who is responsible for the development and implementation of the policies and procedures of the Plan with respect to privacy of Protected Health Information. The Plan must also designate a contact person or office that is responsible for receiving complaints under this Section and who is able to provide further information about matters covered by the notice described above. These designations must be documented by the Plan.

(b) The Plan must train all members of its workforce on the policies and procedures with respect to Protected Health Information required by this Section, as necessary and appropriate for the members of the workforce to carry out their function within the Plan. The Plan must document such training.

(c) The Plan must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information.

(d) The Plan must provide a process for individuals to make complaints concerning the Plan's policies and procedures required by this Section or its compliance with such policies and procedures or the requirements of this Section. The Plan must document all complaints received, and their disposition, it any.

(e) The Plan must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the Plan or the requirements of this Section. The Plan must document the sanctions that are applied, if any.

(f) The Plan must mitigate, to the extent practicable, any harmful effect that is known to the Plan of a use or disclosure of Protected Health Information in violation of its policies and procedures or the requirements of this Section by the Plan or its Business Associates.

(g) The Plan may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for the exercise by the person of any right under this Section or the HHS Regulations.

(h) The Plan may not require individuals to waive their rights under this Section as a condition of the provision of Treatment, Payment, and enrollment in the Plan, or eligibility for benefits.

(i) The Plan must implement and document policies and procedures with respect to Protected Health Information that are designed to comply with the requirements of this Section. The Plan must retain the documentation required by this Section for six years from the date of its creation or the date when it last was in effect, whichever is later.

(j) The Plan shall change its policies and procedures as necessary and appropriate to comply with changes in the law, including the standards, requirements, and implementation specifications of the HHS Regulations.

8.14 Security Rule Compliance.

In order to comply with the requirements of the HIPAA Security Rule as issued by the HHS, the Plan Sponsor shall:

(a) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan;

(b) Implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the Plan's electronic Protected Health Information;

(c) Ensure that adequate separation of the Plan and the Sponsoring Employer is supported by reasonable and appropriate security measures;

(d) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information, agree to implement reasonable and appropriate safeguards to protect electronic Protected Health Information;

(e) Report to the Plan any security incident of which it becomes aware that may threaten the integrity and confidentiality of electronic Protected Health Information; and

(f) Make its policies and procedures and documentation relating to Security Rule safeguards available to HHS for purposes of determining the Plan's compliance therewith.

8.15 Breach Notification.

(a) The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Plan to have been, accessed, acquired, used, or disclosed as a result of such Breach.

(b) A Breach shall be treated as discovered by the Plan as of the first day on which such Breach is known to the Plan, or, by exercising reasonable diligence, would have been known to the Plan. The Plan shall be deemed to have knowledge of a Breach if such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is a workforce member or agent of the Plan.

(c) Except as provided in subparagraph (g), below, the Plan shall provide the notification required under this Section without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach.

(d) The notification required by this Section shall be written in plain language and shall include, to the extent possible:

(i) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

(ii) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(iii) Any steps individuals should take to protect themselves from potential harm resulting from the Breach;

(iv) A brief description of what the Plan is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and

(v) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.

(e) The notification required by this section shall be provided in the following form:

(i) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available;

(ii) If the Plan knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under § 164.502(g)(4) of the HHS Regulations), written notification by first-class mail to either the next of kin or personal representative of the individual;

(iii) In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under subparagraph (i), a substitute form of notice reasonably calculated to reach the individual shall be provided. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under subparagraph (ii);

(iv) In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means;

(v) In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall: 1) be in the form of either a conspicuous posting for a period of 90 days on the home page of the Web site of the Plan, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the Breach likely reside; and 2) include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's Unsecured Protected Health Information may be included in the Breach; or

(vi) In any case deemed by the Plan to require urgency because of possible imminent misuse of Unsecured Protected Health Information, the Plan may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under this paragraph (e).

(f) For a Breach of Unsecured Protected Health Information involving more than 500 residents of a state or jurisdiction, the Plan shall, following the discovery of the Breach, notify prominent media outlets serving the state or jurisdiction. Such notification shall be made without unreasonable delay and in no case later than 60 calendar days after discovery of the Breach and shall meet the requirements set forth in paragraph (d).

(g) The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify the Secretary of Health and Human Services.

(i) For Breaches of Unsecured Protected Health Information involving 500 or more individuals, the Plan shall, except as provided in paragraph (h), below, provide the notification required by this paragraph (g) contemporaneously with the notice required by the foregoing provisions of this Section and in the manner specified on Department of Health and Human Services Web site.

(ii) For Breaches of Unsecured Protected Health Information involving less than 500 individuals, the Plan shall maintain a log or other documentation of such Breaches and, not later than 60 days after the end of each calendar year, provide the notification required by the paragraph for Breaches occurring during the preceding calendar year, in the manner specified on the Department of Health and Human Services Web site.

(h) If a law enforcement official states to the Plan that a notification, notice, or posting required under this section would impede a criminal investigation or cause damage to national security, the Plan shall:

(i) If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or

(ii) If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and not longer than 30 days from the date of the oral statement, unless a written statement as described in Section 8.11(a), above, is submitted during that time.

APPENDIX A
EMPLOYEE WELFARE BENEFITS

PRIME HEALTHCARE WELFARE BENEFITS PLAN

TYPE OF BENEFIT	FULLY-INSURED PLAN ISSUERS	POLICY NO.
Dental	Delta Dental of California PPO Delta Dental of California DeltaCare DHMO 12A MetLife Dental Active PPO and Safeguard DHMO Aetna Dental	16083 76738 142822-1-G 812326
Vision	Vision Service Plan (VSP) Davis Vision	12298135 503884-A
EAP	ComPsych Corporation – Sun Life Assurance Company of Canada	93678 93706 08751 10378 231636
Life/ LTD/STD/AD&D	Sun Life Assurance Company of Canada	93678 93706 08751 10378 231636

TYPE OF BENEFIT	SELF-INSURED PLAN CONTRACT ADMINISTRATORS	POLICY NO.
Dental	Delta Dental of California PPO	15972 19796
Group Medical and Prescription Benefits	Keenan & Associates Express Scripts Rx	N/A N/A
Medical Expense Reimbursement Plan (MERP)	Catilize Health	N/A
FSA/COBRA	HR Simplified	N/A

PRIME HEALTHCARE FOUNDATION WELFARE BENEFITS PLAN

TYPE OF BENEFIT	FULLY-INSURED PLAN ISSUERS	POLICY NO.
Dental	Delta Dental of California PPO Delta Dental of California DeltaCare HMO MetLife Active PPO and Safeguard DHMO	16083 76738 142822
Vision	Vision Service Plan (VSP)	12298135
EAP	ComPsych Corporation – Sun Life Assurance Company of Canada Coastline EAP	93678 93706 10380 231636 239412 N/A
Life/Disability/AD&D	Sun Life Assurance Company of Canada	93678 93706 10380 231636 239412

TYPE OF BENEFIT	SELF-INSURED PLAN CONTRACT ADMINISTRATORS	POLICY NO.
Dental	Delta Dental of California PPO	16023
Group Medical and Prescription Benefits	Keenan & Associates Express Scripts Rx	N/A N/A
Medical Expense Reimbursement Plan (MERP)	Catilize Health	N/A
FSA/COBRA	HR Simplified	N/A

APPENDIX B
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Prime Healthcare Benefits Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

- The Plan's uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and with the Secretary of HHS; and
- The person or office to contact for further information about the Plan's privacy practices.

The term **"Protected Health Information" (PHI)** includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term **"Individually Identifiable Health Information"** means information that:

- Is created or received by a health care provider, health plan, Employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

SECTION 1: Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating Specialist the name of your treating Physician so that the Specialist may ask for your X-rays from the treating Physician.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health Care Operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities. However, the Plan will not use your genetic information for underwriting purposes.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

The Plan will not use or disclose your protected health information for marketing and will not sell your protected health information, unless you give us a written authorization.

The Plan will require written authorization for any other use or disclosure not described in this Notice.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment that you do not object to the disclosure.
- The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an Emergency Services circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

- When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
- When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the

Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

- Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other Injury, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

- The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

- The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law

enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

- The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.
- When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

SECTION 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of Emergency Services and the restricted PHI is needed to provide the Emergency Services, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for Emergency Services, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan will comply with any restriction request if (i) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full out of pocket by you or another person.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

"Designated Record Set" is defined as a group of records maintained for a covered entity. They include medical information and records about the individual maintained by or for a covered provider; the enrollment, payment, claims and adjudication, and case or medical management record systems maintained by or for a health plan; and used in whole or in part, by or for the covered entity to make decisions about individuals. Record means any item, collection or grouping of information that includes PHI and is maintained by, collected, used, or disseminated by or for a covered entity.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with

a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request an amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six (6) years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (i) to carry out treatment, payment or health care operations; (ii) to individuals about their own PHI; (iii) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (iv) pursuant to an authorization; (v) to certain persons involved in your care or payment for your care; (vi) to notify certain persons of your location, general condition or death; (vii) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (viii) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six (6) years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or,
- In lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

2.6 The Right to Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

2.7 Right to Be Notified of a Breach

You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

2.8 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

SECTION 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on Page 1 of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

- However, the minimum necessary standard will not apply in the following situations:
- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS.
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
- Uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

SECTION 4: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

SECTION 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual:

Clay Wombacher
Chief Compliance Officer
Prime Healthcare Management
3480 E. Guasti Road
Ontario, CA 91761
Telephone: (909) 638-0092
Email: CWombacher@primehealthcare.com

CONCLUSION

PHI use and disclosure by the Plan is regulated by a Federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standard.