

**TOWN OF HOPE MILLS**  
**MEDICAL EXPENSE REIMBURSEMENT PLAN**

**PLAN SUMMARY**

## PLAN SUMMARY

The Town of Hope Mills maintains the Town of Hope Mills Medical Expense Reimbursement Plan (the "Plan") for the benefit of its eligible employees and the eligible employees of any affiliated company that adopts the Plan. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

***IDENTIFYING INFORMATION***

1. Plan Name:

Town of Hope Mills Medical Expense Reimbursement Plan

2. Employer Name and Address:

Town of Hope Mills  
5770 Rockfish Road  
Hope Mills, NC 28348

3. Plan Administrator:

Town of Hope Mills  
5770 Rockfish Road  
Hope Mills, NC 28348  
910 426-4115

4. Claims Administrator:

Your Employer has retained P&A Administrative Services, Inc. to assist in Plan Administration. ***All claim forms should be submitted to:***

P&A Administrative Services, Inc.  
17 Court Street - Suite 500  
Buffalo, New York 14202

**Claims may be faxed to 716 855-7105 or emailed to [Flexclaims@padmin.com](mailto:Flexclaims@padmin.com).**

5. Plan Year-End:

June 30

## ***THE MEDICAL EXPENSE REIMBURSEMENT PLAN***

### ***OVERVIEW***

The Plan is intended to reimburse you for some of your uninsured, out-of-pocket costs for health care. The following is a list of some of the more commonly asked questions regarding your Plan.

### ***EFFECTIVE DATE AND PLAN YEAR***

#### **WHAT IS THE EFFECTIVE DATE OF THE PLAN?**

The Plan started on July 1, 2010. The Plan's benefit limits were increased effective July 1, 2011.

#### **WHAT IS THE PLAN YEAR?**

"Plan Year" refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on July 1 and ending on the following June 30.

### ***ELIGIBILITY AND PARTICIPATION***

#### **WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?**

To be eligible for the Plan, you must be covered by the BlueCross BlueShield of North Carolina PPO Health Plan coverage option under the Employer's group health insurance plan. If you are an eligible employee, you qualify for benefits by becoming a "Participant" as soon as your BlueCross BlueShield of North Carolina PPO Health Plan insurance coverage starts.

### ***PLAN CONTRIBUTIONS***

#### **WHO PAYS FOR THE COST OF PLAN BENEFITS?**

All benefits under the Plan are paid by the Employer. However, if you elect the COBRA or USERRA Continuation Coverage described below, you will be required to pay premiums to receive the coverage.

#### **WHO PAYS FOR THE COST OF PLAN ADMINISTRATION?**

The Employer pays for the cost of Plan administration.

### ***PLAN BENEFITS***

#### **WHAT BENEFITS MAY I RECEIVE UNDER THIS PLAN?**

Your BlueCross BlueShield of North Carolina PPO Health Plan insurance includes separate annual deductibles that apply to services that you receive from members of the insurance carrier's network of service providers (called the "in-network deductible") and to services that you receive from other health care providers (called the "out-of-network deductible"). Your insurance will not pay for the cost of your health care in any year until your total health care expenses for that year exceed the amount of the applicable annual deductible.

Your coverage also includes separate coinsurance provisions that apply to in-network and out-of-network services. These coinsurance provisions require you to share the cost of your health care with the insurance company once your total expenses for a Plan Year reach a certain level.

This Plan will reimburse you for some of the health care expenses that are not paid by your insurance because of *in-network deductible and the in-network coinsurance provision*. If you have family coverage, the expenses of your Spouse and your Dependents who are covered by your health insurance also are eligible for reimbursement.

Before qualifying for benefits, you must first pay a portion of these expenses on your own. This Plan will reimburse you for the cost of in-network deductible expenses only after you have paid the first \$500 of those expenses that you had in the same Plan Year. The Plan will reimburse you for the cost of in-network coinsurance expenses only after you have paid the first \$2,000 of those expenses that you had in the same Plan Year.

There is a limit on the total amount of reimbursement that you may receive for eligible expenses that you have within the same Plan Year. If you have single health insurance coverage on a particular date, your annual limit on that date will be \$4,500 for deductible expenses and \$2,000 for coinsurance expenses. If you have family insurance coverage on a particular date, your annual limit on that date will be \$9,000 for deductible expenses and \$4,000 for coinsurance expenses.

## **WHO IS A SPOUSE AND WHO IS A DEPENDENT?**

Under the Plan, only the expenses of a Participant, a Participant's Spouse or a Participant's Dependent may be reimbursed. According to the laws that apply to the operation of the Plan, an individual may be treated as the "Spouse" of a Participant only if the individual is of the opposite sex and is considered to be married to the Participant under the laws of the state where the Participant and the other individual live.

Even though a partner of the same sex cannot qualify as a Spouse, he or she may still qualify as a "Dependent". To qualify as a Dependent, a same sex partner (or any other person who is not related to a Participant) must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;
2. have the same principal residence as the Participant for the entire calendar year; and
3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement of the expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of this Plan, "Dependent" includes any child of a Participant whose 27<sup>th</sup> birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

## ***BENEFIT CLAIMS***

## HOW DO I OBTAIN BENEFITS?

You may obtain reimbursement for your eligible expenses by submitting (i) a claim form, (ii) documentation from the provider of the services that you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expenses, and (iii) an Explanation of Benefits from your health insurance carrier to the Claims Administrator in accordance with procedures established by the Claims Administrator and the Plan Administrator. The Claims Administrator will determine the extent to which the expenses are covered and will pay any benefits due to you under the Plan. **You must submit your claims for expenses that occur during a Plan Year by the last day of the next Plan Year.**

If your claim arises while you are receiving COBRA Continuation Coverage, your premium payments must be up-to-date (subject to a thirty-day grace period for late payment) to receive benefits.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

## WHAT ARE MY RIGHTS IF MY CLAIM FOR BENEFITS IS DENIED?

### *When a Claim is Denied*

You will be notified in writing by the Claims Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claim Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. The reason or reasons that your claim was denied;
2. The specific Plan provision on which the denial was based;
3. A description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and
4. Information on the steps that you must take to appeal the Claims Administrator's decision, including your right to submit written comments and have them considered, and your right to review, upon request and at no charge, relevant documents and other information.

### *Appealing a Claim Denial*

If the Claims Administrator denies your claim or any part of your claim, you or an authorized representative of yours may apply to the Claims Administrator's Benefits Manager to review the denial. Your appeal must be made in

writing within 180 days after you received notification from the Claims Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

#### *Decision on Review*

The Claims Administrator's Benefits Manager will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Benefits Manager may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. The specific reasons for the decision on review;
2. The specific Plan provision or provisions on which the decision is based;
3. A statement of your right to review, upon request and at no charge, relevant documents and other information; and
4. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

#### **UNDER WHAT CIRCUMSTANCES WILL I LOSE THE RIGHT TO SUBMIT CLAIMS?**

You will lose eligibility for benefits if you stop working for the Employer or you stop being covered by the BlueCross BlueShield of North Carolina PPO Health Plan coverage option for any other reason. When you lose eligibility:

1. Your future expenses will not qualify for reimbursement under the Plan.
2. You will be permitted to submit claims for eligible expenses that you had in the current Plan Year before you lost eligibility.
3. Your remaining claims must be submitted by the last day of the following Plan Year.

#### ***CONTINUATION COVERAGE***

#### **WHAT HAPPENS IF I GO OUT ON FMLA LEAVE?**

The Family Medical Leave Act ("FMLA") entitles certain employees to take unpaid leaves of absence totaling twelve weeks per year for specified personal or family health and child care needs. Your coverage under the Plan during any FMLA leave will continue at no cost to you. However, you will lose coverage (subject to your right to elect COBRA

Continuation Coverage) if you fail to return to work at the end of the leave or if you give earlier notice of your intention not to return from the leave.

## **WHAT HAPPENS IF I TAKE MILITARY LEAVE?**

If you take a leave of absence from the Employer in connection with duty in the uniformed services, the Plan will continue to cover you on the same basis as an active employee (except for expenses directly related to the military service, e.g., combat-related injuries) if the period of the leave is expected to be less than thirty one days. For leaves of a longer duration, you may elect to continue coverage in the plan at your own expense for up to twenty-four months. The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

## **MAY I CONTINUE MY PARTICIPATION IN THE PLAN IF I BECOME INELIGIBLE (BECAUSE, FOR EXAMPLE, MY EMPLOYMENT TERMINATES?)**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), allows certain individuals to continue their health plan coverage at their own expense when that coverage otherwise would end. The purpose of this section of the Summary is to **explain the COBRA rules that could allow you to continue your coverage under the Medical Expense Reimbursement Plan at the time you would otherwise lose eligibility. NOTE: YOU MAY ONLY ELECT CONTINUATION COVERAGE UNDER THIS PLAN IF YOU ALSO ELECT TO CONTINUE YOUR BLUECROSS BLUESHIELD OF NORTH CAROLINA PPO HEALTH PLAN COVERAGE UNDER COBRA.**

### *COBRA Coverage*

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your Spouse will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both); or
5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both);
5. You and your Spouse become divorced or legally separated; or
6. He or she stops being eligible for coverage under the Plan as a "Dependent".

#### *Notifying the Plan Administrator of Qualifying Events*

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

#### *How to Provide Notice*

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

The Plan's form titled, "Notice of Qualifying Event", should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

See the information below regarding how the occurrence of a second qualifying event may affect the length of COBRA continuation coverage that is available. Any notice that you provide of a second qualifying event must include the same type of information that was included in your notice of the first qualifying event. The Plan's form titled, "Notice of Second Qualifying Event", should be used to notify the Plan Administrator of a second qualifying event. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the second qualifying event occurs.

See the information below regarding how a determination by the Social Security Administration that a qualified beneficiary is disabled may affect the length of COBRA continuation coverage that is available. Any notice of disability that you provide must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination that he or she is disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form titled, "Notice of Disability Determination", should be used to notify the Plan Administrator of a disability determination. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the Social Security Administration makes its determination and before the end of the first 18 months of COBRA continuation coverage.

#### *Electing COBRA Coverage*

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately. Also, you or your Spouse may elect coverage for your minor children.

A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

#### *Length of COBRA Coverage*

When the qualifying event is your death, your enrollment in Medicare (Part A, Part B or both), your divorce or legal separation or your Dependent losing eligibility as a Dependent, COBRA coverage lasts for up to 36 months. When the qualifying event is the end of your employment or a reduction in your work hours and you became entitled to Medicare benefits less than 18 months before that qualifying event, COBRA coverage for other family members lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of your employment or reduction in your work hours, COBRA coverage generally lasts for up to 18 months. There are three ways in which this 18-month period of COBRA coverage can be extended.

#### *Second qualifying event extension of 18-month period of COBRA coverage*

An 18-month extension of coverage will be available to other family members if a second qualifying event occurs during the first 18 months of their continuation coverage. The maximum amount of total COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include your death, your divorce, your enrollment in Medicare or a child losing status as a Dependent.

If a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days to obtain the extension.

#### *Medicare extension for Spouse and Dependents*

If your employment ends or your work hours are reduced within 18 months after you become entitled to Medicare, the maximum coverage period for your Spouse and Dependents will end three years from the date you enrolled in Medicare.

#### *Disability extension of 18-month period of COBRA coverage*

An 11-month extension of coverage may be available if you or another family member receiving COBRA is disabled. For the extension to be available, the Social Security Administration ("SSA") must determine that the family

member was disabled during the first 60 days of COBRA coverage, and you must notify the Plan Administrator of that fact in writing within 60 days after the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability extension is available, it will apply to the COBRA coverage of all family members, not just the disabled family member.

You must notify the Plan Administrator within 30 days if the SSA determines that the family member has stopped being disabled at any time before the extension coverage period ends. COBRA coverage for all qualified beneficiaries will terminate when this occurs. The plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

#### *Termination of COBRA Coverage before the End of the Maximum Coverage Period*

Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) the Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

#### *Cost of COBRA coverage*

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

#### *Payment for COBRA coverage-First payment*

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

#### *Payment for COBRA coverage- Periodic payments*

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

#### *Grace periods for periodic payments*

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment

later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. 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 Have Questions*

If you have questions about your COBRA coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### *Keep Your Plan Informed of Address Changes*

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **MISCELLANEOUS**

### **WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A CAFETERIA PLAN OF THE EMPLOYER?**

If you have an expense that is an eligible expense under a cafeteria plan as well as under this Plan, the expense must be reimbursed by this Plan to the extent that you are eligible for reimbursement of expenses under this Plan.

### **CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?**

Although the Employer presently anticipates the Plan continuing indefinitely, it has the right to amend or terminate the Plan at any time.

### **WHAT OTHER RULES APPLY TO MY PARTICIPATION?**

### **MATERNITY BENEFITS**

Under federal law, group health plans (including this Plan) and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that authorization be obtained from the plan or the insurance issuer for prescribing a length of stay not in excess of these periods.

### **HIPAA PRIVACY RIGHTS**

The Claims Administrator for the Plan may come into possession of certain information about you and your family members that is considered "protected" under the HIPAA law. The Claims Administrator will treat this information as confidential and will disclose this type of information only for the specific purposes of your health care treatment, paying for your health care and for "health care operations" as that term is defined under HIPAA.

The Claims Administrator will disclose your protected health information to the Employer only after the Employer certifies that the Plan documents have been amended to provide that the Employer will:

1. Not use or disclose protected health information other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Employer provides protected health information received from the Claims Administrator agree to the same restrictions and conditions that apply to the Employer regarding the use and disclosure of protected health information;
3. Not use or disclose protected health information for employment-related actions and decisions unless you have authorized it;
4. Not use or disclose protected health information in connection with any of the Employer's other benefit plans unless you have authorized it;
5. Report to the Claims Administrator any use or disclosure of protected health information that the Employer becomes aware of;
6. Make your protected health information available to you according to HIPAA's access requirements;
7. Make protected health information available for amendment and incorporate any amendments to protected health information in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures; make internal practices, books and records relating to the use and disclosure of protected health information received from the Claims Administrator available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA; and
9. If possible, return or destroy all protected health information received from the Claims Administrator that the Employer still maintains in any form, and retain no copies of that protected health information when no longer needed for the purpose for which it was disclosed (or, if return or destruction is not possible, limit further uses and purposes that make it impossible to return or destroy the information).

In compliance with HIPAA, only a select group of employees are permitted to receive protected health information on behalf of your Employer. As of July 1, 2011, the only employee permitted to receive this type of information for the Employer is the Employer's Human Resources Administrator. Any protected health information that these employees receive may be used only for purposes of administering this Plan. Your Employer will provide a mechanism for resolving issues regarding whether the designated individuals have violated the limitations that apply, including possible disciplinary sanctions.

**THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.**