

# **CHEMUNG COUNTY**

**FLEXIBLE BENEFIT PLAN DOCUMENT**

**AND**

**SUMMARY PLAN DESCRIPTION**

*Revised January 1, 2018*

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**CHEMUNG COUNTY  
203-205 Lake St  
ELMIRA, NY 14901**

**PLAN SUMMARY**

- a) **Plan Name:** CHEMUNG COUNTY  
Flexible Benefit Plan
- b) **Plan Sponsor:** CHEMUNG COUNTY  
203-205 Lake St  
ELMIRA, NY 14901  
(607) 737-2918
- c) **Employer Tax ID#:** 16-6002557
- d) **Plan #:** 501
- e) **Type of Plan:** § 125 Flexible Benefit Plan
- f) **Plan Administrator:** CHEMUNG COUNTY
- g) **Employer:** CHEMUNG COUNTY
- h) **Service of Legal Process:** CHEMUNG COUNTY
- i) **Eligibility:** Refer to Article 3 of the document
- j) **Contributions:** Provided by the Employer and the Employees
- k) **Effective Date:** January 1, 1992
- l) **Claim Administrator:** SIEBA, LTD.  
111 Grant Ave, Ste 202  
PO Box 5000  
Endicott, NY 13761-5000  
(607) 786-3003  
(800) 252-4624
- m) **Group #:** 997

## FLEXIBLE BENEFIT MANUAL CLAIMS PROCEDURE

1. Complete a claim form with EVERY submission. BE SURE ALL INFORMATION IS COMPLETE.
2. STAPLED to the claim form should be legible copies of documentation to support your request for reimbursement.

*THIS DOCUMENTATION MAY INCLUDE, BUT IS NOT LIMITED TO:*

- A. Explanation of benefits from all Health benefit carriers involved, if applicable.
- B. Copies of walkout statements noting co-pay amounts, bills, or itemized prescription receipts. (Cash register receipts acceptable for Over the Counter "OTC" products only. Don't forget a physician's prescription for Over the Counter medicines and drugs).

### THIS DOCUMENTATION MUST BE ITEMIZED AND SHOULD INCLUDE:

- Name of Provider of Service
- Address and Tax ID # of Provider
- Patient's Name
- Date of Service
- Type of Service Provided. (i.e. "office visit", "x-ray", etc)
- Charged Amount for each Service Provided
- Health Benefit Payments (if applicable) made toward the charge for each date of service

Statements showing ONLY received on account (ROA), paid on account (POA), balance due, balance forward, or previous balance are not acceptable forms of documentation and will be returned to you for insufficient information.

The more specific documentation you provide the less chance of returned claims and/or delays in claim processing.

- C. For DEPENDENT CARE, the required documentation must be a paid receipt showing the dates of service, who the care was provided for, amount(s) charged, name, address and Tax ID # (or social security number) of the provider, (this should be a 9 digit number).
3. Mail or fax your completed claim form and documentation to:

SIEBA, LTD.  
Group 997  
111 Grant Ave, Ste 202  
PO Box 5000  
Endicott, NY 13761-5000

4. If you have any problems or questions regarding claims, or account status call:  
SIEBA LTD at: (607) 786 - 3003 or (800) 252-4624 FAX: (607) 786-3437

**CHEMUNG COUNTY  
FLEXIBLE BENEFITS PLAN**

**ARTICLE 1 - GENERAL PROVISIONS**

**1.1 PLAN NAME**

This Plan shall be known as the CHEMUNG COUNTY Flexible Benefit Plan.

**1.2 PURPOSE**

This document is intended to provide an explanation of the CHEMUNG COUNTY Flexible Benefit Plan.

**1.3 DESIGN**

The CHEMUNG COUNTY Flexible Benefit Plan is designed to qualify as a cafeteria plan within the meaning §125 of the Internal Revenue Code of 1986, as amended, in order that Benefits which an Employee elects to receive under said Plan may be included or excluded from the Employee's income under §125 (a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

**ARTICLE 2 - DEFINITIONS**

**2.1 DEFINITIONS**

**Benefit** – means any of the benefit choices available to a Participant, as said choices are outlined in Article 4 of this Plan and is considered a qualified benefit as described in §125(f) of the Code and the regulations set forth thereunder.

**Benefit Account** – means each specific account established for a Participant pursuant to the Plan to which his Salary Redirection may be allocated and from which Expenses of the Employee and their Dependents may be reimbursed.

**Claim Administrator** – means the individual or corporation appointed by the Employer to administer the Plan. If an administrator has not been appointed or resigns from an appointment, the Employer shall be deemed to be the administrator, unless a replacement administrator shall be appointed.

**Code** – means the Internal Revenue Code of 1986, as same has been or may be amended from time to time.

**Compensation** – means earned income, salary, wages, fees, commissions, overtime, bonuses, tips and all other earnings of a Participant, reportable on Form W-2 for the Plan Year including amounts contributed by an Employee to the Plan, but excluding all other contributions to any other plan Sponsored by the Employer, and all other forms of Compensation.

**Dependent** – means a dependent of the Participant within the meaning of §105 (b) of the Code and/or a child of a Participant who is considered eligible under §105(b) of the Code. A child under this definition is any son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Employee who is age 26 or younger for the entire calendar year.

**Dependent Care Assistance Account (DCA)** – means an account established from which Dependent Care (day care) Expenses can be reimbursed for eligible Dependents.

**Dependent Care Expense** – means an amount paid for the care of a Dependent (as defined above) or for related household services that are incurred to enable you (and your spouse if married) to be gainfully employed. These Expenses must be for dependent care purposes as said term is used in §129 of the Code as outlined in IRS publication 503. Dependent Care Expenses are subject to change at any time in accordance with applicable changes to the IRS Code.

**Effective Date** – means January 1, 1992.

**Election Period** – means the thirty (30) days prior to the commencement of a new Plan Year, which period is set aside for the election of benefits and salary redirection. Notwithstanding the foregoing, an employee's initial election period shall be determined pursuant to the provisions of Section 5.1 of Article 5 of this Plan.

**Employee** -- means a person who is employed by the Employer, including a leased Employee within the meaning of §414(n)(2) of the Code, but excluding a person who is employed as an independent contractor and who qualifies under the provisions of Section 3.1 of Article 3 of this Plan.

**Employer** -- means the CHEMUNG COUNTY and its' affiliated entities, and any successor entity which shall maintain this Plan.

**Expense** -- means amounts paid or incurred by the Employee and his Spouse and/or Dependents for Benefits not otherwise reimbursed under any group plan, the reimbursement of which by the Employer is intended to be excluded from the income of such Participant under various provisions of the Code.

**Health** -- means medical, dental, cancer, group term life, vision and other health related benefits or coverages offered by the Employer.

**Health Flexible Spending Account (FSA)** – means an account established from which Medical Expenses can be reimbursed.

**Health Premiums** -- means premiums paid for such coverages as medical, dental, cancer, group term life, vision and other health related benefits or coverages offered by the Employer and allowed by the IRS Tax Code. This does not include dependent life insurance premiums as outlined by the IRS Tax Code.

**Highly Compensated Employee** -- means an Employee whose income or ownership percentage exceeds the limits defined in §414(q) of the Code.

**Key Employee** -- means an Employee who is a key officer or key owner of the Sponsor as defined in § 416(i)(1) of the Code.

**Medical Expense** -- means an amount paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. The term may include Expenses for routine and extraordinary physical, mental and dental examinations, surgery, psychiatric care, hospitalization, drugs and medicines, vision care, therapeutic, orthopedic, and prosthetic aides and devices, transportation primarily for and essential to medical care, and all other Expenses that are considered to be for medical care as said term is used in § 105 of the Code. Medical Expenses are subject to change at any time in accordance with applicable changes to the IRS Code and subsequent other IRS Rulings, interpretation, and guidance.

**Participant** -- means an Employee who meets the requirements of Article 3 of this Plan.

**Pay Period** -- means those pay periods specified by the Sponsor of which salary reductions will be withheld.

**Plan** -- means the CHEMUNG COUNTY Flexible Benefit Plan set forth herein or same as it may be amended from time-to-time.

**Plan Administrator** -- means the Sponsor which is CHEMUNG COUNTY

**Plan Year** -- means the period beginning on the January 1<sup>st</sup> and ending on December 31<sup>st</sup>.

**Salary Redirection** -- means the portion of a Participant's Compensation which the Participant has elected to reserve for the payment or reimbursement of Benefits under the Plan for a Plan Year.

**Salary Redirection Agreement** -- (also called an enrollment/election form) means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code § 125 into account) and, subsequently does not become currently available to the Participant.

**Sponsor** -- means the CHEMUNG COUNTY whose principal place of business is located at 203-205 Lake St, ALMOND, NY 14901, telephone number (607) 737-2918 or any successor entity that assumes the obligations created by this Plan.

## **2.2 GENDER AND NUMBER**

Whenever the context so requires, the use of words in this agreement in the singular shall be construed to include the plural and words in the plural shall be construed to include the singular. Words, whether they are in the masculine, feminine or neuter gender, shall be construed to include all of the said genders unless the context would require that the gender apply to only one sex. By the use of the aforesaid genders, it is understood that it is for convenience purposes only and that said use is not to be interpreted to be discriminatory by reason of sex.

## **ARTICLE 3 - PARTICIPATION**

### **3.1 ELIGIBILITY**

An Employee is eligible to participate in the CHEMUNG COUNTY GOVERNMENT Flexible Benefit Plan if he is a permanent Employee of CHEMUNG COUNTY GOVERNMENT and eligible for the CHEMUNG COUNTY GOVERNMENT Group Health Plan. Eligibility shall also be subject to the additional requirements, if any, as specified in the Employee's personnel policy and the Health Benefit programs listed on Attachment C.

### **3.2 PARTICIPATION DATE AND ELECTION**

An Employee is eligible to participate in the CHEMUNG COUNTY GOVERNMENT FLEXIBLE BENEFIT PLAN Health Premium Benefit (4.1) at the same time he is eligible to participate in a Health Benefit program offered by CHEMUNG COUNTY GOVERNMENT.

An Employee is eligible to participate in the CHEMUNG COUNTY GOVERNMENT FLEXIBLE BENEFIT PLAN Health Flexible Spending Account (4.2) or Dependent Care Assistant Account (4.3) as of the first Plan Year following the date of eligibility. An Employee who wants to participate must execute a Salary Redirection Agreement before participation in the Plan as outlined in Article 5 of this document.

### **3.3 DURATION OF PARTICIPATION**

Except as otherwise provided by the Plan, an Employee shall continue as a Participant as long as he remains in the employ of the Sponsor and continues to meet the eligibility requirements of Section 3.1 of this Article.

### **3.4 FMLA LEAVE**

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any group health plan (including an unreimbursed medical account) offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall be affected in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

## ARTICLE 4 - BENEFITS

### 4.1 HEALTH PREMIUM BENEFIT

- (a) All Employees who are required to contribute to the cost of their Health plans will automatically become a Participant in the Health Premium Benefit of this Plan and the amount of contribution will be withheld on a pre-tax basis. This election will remain in force until an affirmative election to change is made. (See Attachment C)
- (b) If an Employee does not desire to have the contribution withheld on a pre-tax basis as outlined above, he may sign a waiver and the contribution will be withheld on an after tax basis This election will remain in force until an affirmative election to change is made..
- (c) If during the Plan Year, the amount of contribution changes, such change will automatically be made to the pre-tax contribution, when permissible in accordance with Section 5.3 of this document.

### 4.2 HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

- (a) An Employee may elect to receive the balance of his Compensation in full or become a Participant in the Plan and apply a portion of his Compensation to reimbursement of Medical Expenses in a Health Flexible Spending Account (FSA).
- (b) The maximum amount that a Participant may redirect from his Compensation to the Health FSA for reimbursement of Medical Expenses in a Plan Year may not exceed the amount of the maximum allowed by the IRS (\$2500 for 2015) or any other amount established by the Employer, but not more than the maximum allowed by the IRS. A Participant may elect to enroll in a General Purpose FSA, a Limited Purpose FSA, or an Employee Only FSA.

i) General Purpose FSA means an account to reimburse expenses incurred by a Participant and/or his Spouse and/or Dependents for medical care, as defined in Code §213(d) – provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through a Health benefit plan, other insurance, or any other accident or health plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the Health benefit plan imposes co-payment or deductible limitation), then the Health FSA can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of this Section. Employees participating in an HSA are NOT eligible to participate in a General Purpose FSA.

ii) Limited Purpose (Vision/Dental/Preventative Care) FSA means an account to reimburse expenses incurred by a Participant and/or his Spouse and/or Dependents for medical care, as defined in Code §213(d) – provided, however that this expense is for vision care, dental care, or preventative care (as defined in Code §223(c)) only, and provided that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through a Health benefit plan, other insurance, or any other accident or health plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the Health benefit plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of the Article. Employees participating in an HSA are eligible to participate in a Limited Purpose FSA only.

iii) Employee-Only FSA means an account to reimburse expenses incurred by a Participant (but not by his Dependents or Spouse) for medical care as defined in Code §213(d) – provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant is reimbursed for the expense through a Health benefit plan, other insurance, or any other accident or health plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the Health benefit plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of this Article. Employees participating in an HSA are NOT eligible to participate in an Employee Only FSA.

#### **4.3 DEPENDENT CARE ASSISTANCE ACCOUNT (DCA)**

- (a) An Employee may elect to receive the balance of his Compensation in full or become a Participant in the Plan and apply a portion of his Compensation to reimbursement of Dependent Care Expenses in a Dependent Care Assistance Account (DCA)
- (b) The maximum amount that a Participant may apply to the DCA Account for reimbursement of Dependent Care Expenses in a taxable year may not exceed the amount established by §129 of the Code. As of January 1, 2018 this amount is \$5,000 for married persons filing jointly per household or single head of household and \$2500 for married filing separately per household.

#### **4.4 MAXIMUM BENEFITS**

- (a) The total Compensation eligible for Salary Redirection in a Plan Year shall not exceed the amounts available from Section 4.1, 4.2, and 4.3 of this document.

#### **4.5 CREDITS TO ACCOUNTS**

A separate Benefit Account shall be maintained for each Benefit selected by a Participant. The amount of the Participant's Salary Redirection, if any, allocated to the reimbursement of Benefits shall be credited to the Benefit Accounts maintained for the Participant. The amount credited to a Benefit Account for each Pay Period shall equal the portion of the Salary Redirection allocated for the Benefit divided by the number of Pay Periods in the Plan Year. Payroll deductions for Salary Redirections shall be equal for each Pay Period. In the event the Salary Redirections are made other than on a pro-rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 4.7.

#### **4.6 REIMBURSEMENT OF BENEFITS**

- (a) Manual claim reimbursements will be made as soon as practicable after requests are submitted to the Claim Administrator. The Claim Administrator will provide claim forms for this purpose. The amount available for reimbursement of Dependent Care Expenses shall equal the amount credited to the DCA to date. The amount available for reimbursement of Medical Expenses shall equal the total amount allocated to the Health FSA. This total amount will be available to the Plan Participants as of the first day of the Plan Year.
- (b) The Plan Administrator has established twenty-five dollars (\$25) as the minimum amount for reimbursement. Notwithstanding the foregoing, if the funds remaining in a Participant's account are less than twenty-five dollars (\$25), the minimum amount for reimbursement shall be the actual funds remaining in the Benefit Account.
- (d) A Participant will receive statements of the balances in his Benefit Accounts for each Benefit. Each Participant is responsible for checking his Benefit Account balances. A Participant must notify the Claim Administrator in writing of any errors in a statement within ninety days of having received the statement. If a discrepancy arises, the information contained on the Participant enrollment form will be the governing document.

- (d) Manual claims for Medical and Dependent Care Expense reimbursements must be submitted no later than ninety (90) days following the end of the Plan Year in which the Expenses are incurred.

#### **4.7 TERMINATION OF EMPLOYMENT**

Upon termination of employment, a Participant may request reimbursement of Expenses for Benefits incurred before the date of termination. The request for reimbursement must be submitted within thirty (30) days after the Employee's termination date. A Participant shall forfeit any portion of his Benefit remaining after the payment of pre-termination claims unless he elects to continue coverage for reimbursement of Medical Expenses in Section 4.8 of this Article. In the event a Participant terminates his participation in the Plan during the Plan Year, if Salary Redirections are made other than on a pro-rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or Benefits relating to the period after the date the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date. If a terminated Employee who has revoked coverage under the Plan is re-employed by the Employer, said Employee shall be prohibited from making a new election in the Plan Year for which revocation was effective, unless a change of status event has occurred. However, the re-employed Employee may receive Benefits under the Plan in accordance with the election which was in effect prior to his termination of employment with the Employer.

#### **4.8 CONTINUATION COVERAGE**

The Plan Administrator shall advise each Participant who terminates employment with the Sponsor of the Participant's rights, if any, to continue health benefit coverage or reimbursement of Medical Expenses pursuant to the provisions of the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA). (See Attachment B)

#### **4.9 INSURANCE BENEFITS**

- (a) All Health plan / insurance benefits payable to Participants are described in the plans, contracts or policies issued by the Health plan administrator / insurance company.
- (b) The Sponsor does not guarantee payment of any claims for benefits arising under any Health/ insurance policy, nor does eligibility under the Plan guarantee that a Participant will satisfy any Health plan/insurer's requirements for eligibility to receive Health benefits / insurance.

#### **4.10 FORFEITURE OF BENEFITS**

A Participant who's Salary Redirection for a Plan Year exceeds the Participant's actual Medical Expenses for the Plan Year will forfeit the unused amount of the Salary Redirection which are less than \$10 and greater than \$500 as of the 91<sup>st</sup> day after the close of the Plan Year. A Participant who's Salary Redirection for a Plan Year exceeds the Participant's actual Dependent Care Expenses for the Plan Year will forfeit the unused amount of the Salary Redirection as of the 91<sup>st</sup> day after the close of the Plan Year. Funds from a Plan Year for Health FSA may be applied only to pay or reimburse Medical Expenses for the Benefit incurred during the same Plan Year. Funds from a Plan Year for DCA may be applied only to pay or reimburse Dependent Care Expenses for the Benefit incurred during the same Plan Year. Forfeited amounts shall revert to the Employer.

#### **4.11 PAYMENT OF CONTRIBUTIONS WHILE ON FMLA LEAVE**

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and who elects to continue participation under this Plan shall be responsible for making the required contributions under the group Health plan(s) offered under this Plan during the period of the FMLA Leave. The manner in which such payments are made shall be determined by the Plan Administrator in its sole discretion in the following manner:

- a) Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayment may not be required as a condition to remaining in the Plan. Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

b) **Pay-As-You-Go:** The contributions due during the FMLA Leave period may be based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

c) **Catch-Up Option:** The Employer may advance the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The "Catch-Up Option" shall be applied in a manner consistent with Prop. Treas. Reg. § 1.125-3.

## **ARTICLE 5 - ELECTION PROCEDURES**

### **5.1 ANNUAL ELECTION**

The Plan Administrator shall provide a Salary Redirection Agreement to each Participant during the Election Period of the Plan. An Employee hired during the Plan Year shall receive his Salary Redirection Agreement form during the month in which he meets the eligibility requirements set forth in Article 3 of this Plan. If the Salary Redirection Agreement is not completed and returned within the stated Election Period, the Employee will be deemed to have elected a \$.00 (zero dollar) election. A Salary Redirection Agreement form must be submitted before the beginning of a Plan Year for an existing Employee or during the Election Period for a new Employee as described in Article 4 of this document. A Participant who elects to receive reimbursement of Medical and/or Dependent Care Expenses shall specify the portion of his Salary Redirection allocated to reimbursement of these costs.

### **5.2 IRREVOCABILITY OF SALARY REDUCTION AGREEMENT**

Once a Salary Reduction Agreement is made, it shall be irrevocable for the rest of the Plan Year, provided, however, that a Participant may change a Salary Reduction Agreement on account of and consistent with a change in status.

### **5.3 PERMISSIBLE CHANGES**

Permissible Changes that could affect the Participants enrolled in a Health Flexible Spending Account (4.2) and/or a Dependent Care Assistance Account (4.3) will apply only to those Employees who are already enrolled the Health Flexible Spending Account (4.2) and/or the Dependent Care Assistance Account (4.3) in the Plan for the Plan Year in which a change of status event takes place. Permissible Changes that could affect Employees who become eligible to participate during the Plan Year will apply only to enrollment in the Health Premium Benefit.

If a change in status event has taken place, a new Salary Reduction Agreement may be made. This new Salary Reduction Agreement must take place within 30 (thirty) days of the change in status event. The new Salary Reduction Agreement must also be consistent with the change in status event. A new Salary Reduction Agreement shall be effective at the time prescribed by the Plan Administrator, but in no event shall it be earlier than the first pay period after the Salary Reduction Agreement is made and the Plan Administrator is notified.

For the purpose of this section, a change in status includes marriage, divorce, separation (where a formal separation agreement exists), death of a spouse or child, birth or adoption of a child, commencement or termination of employment of a spouse, a change between full-time and part-time employment, an unpaid leave of absence or any other event that may permit a change of a Salary Reduction Election in accordance with the IRC during a Plan Year. Refer to the specific changes in status events on Attachment A.

### **5.4 NON-DISCRIMINATION REQUIREMENTS**

The Plan Administrator may in its sole and absolute discretion take any action that it deems appropriate to assure compliance with all applicable nondiscrimination requirements and all applicable limitations on Benefits provided to Key Employees or Highly-Compensated Employees in accordance with the Code. Action may include, without limitation, the modification of Salary Redirection Agreements by a Key Employee or a Highly-Compensated Employee with or without his consent.

## **ARTICLE 6 - PLAN ADMINISTRATION**

### **6.1 PLAN ADMINISTRATOR**

The Sponsor shall be the Plan Administrator. The Sponsor is the named fiduciary with full authority and responsibility to control and manage the operation and administration of the Plan. The Plan is subject to contract administration. The Sponsor can be contacted at the address and telephone number provided in Article 2 of this Plan. The Sponsor is also designated as the agent for service of legal process. Legal process may be served upon the Sponsor at the address provided in Article 2 of this Plan.

### **6.2 POWERS**

The Sponsor shall have the exclusive right to interpret the Plan, but not to modify or amend said Plan, and to decide any and all questions arising out of the administration, interpretation and application of the Plan. The Sponsor shall establish any rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of the Sponsor or its action with respect to the Plan shall be conclusive and binding on all persons having or claiming to have any right or interest in or under the Plan.

### **6.3 RECORDS**

The Claim Administrator shall maintain accounts showing the transactions of the Plan.

### **6.4 MANUAL CLAIMS PROCEDURES**

Participants may request to receive Benefits under the Plan by submitting a written claim for Benefits to the Claim Administrator. The Claim Administrator will review the claim within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that either the Plan Administrator or the Claims Administrator (1) determine that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary to obtain additional information from the claimant, the notice shall describe the specific information needed, and the claimant shall have 45 days from receipt of the notice to provide information. Without complete information, the claim will be denied. The claimant shall then be provided with a notice of denial. The notice shall set forth in a manner calculated to be understood by the claimant, the following information: (A) The specific reason or reasons for the denial; (B) Specific reference to pertinent Plan provisions on which the denial is based; (C) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary; (D) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA § 502(a) following an adverse benefit determination; and (E) A copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or, in lieu thereof, a statement that such information is available free of charge upon request. If a claim is denied, in whole or in part, because it exceeds a claimant's annual benefit limit, the initial denial notice containing the explanation for denial shall serve as notice of denial for all subsequent claims submitted by the claimant during that benefit year. Any claims submitted after the initial denial notice that states the claim exceeds the claimant's annual benefit limit will be considered denied as of the date submitted. The claimant may request a year to date summary of claims paid from his Plan.

### **6.5 REVIEW PROCEDURE**

If a claim is denied in whole or in part, the claimant has a right to a full and fair review. Within 180 days after the date on which the claimant receives written notice of a denied claim, the claimant, or the claimant's authorized representative, may file a written request with the Plan Administrator for a review of the denied claim. The claimant may submit to the Plan Administrator, written comments, documents, or other information in support of his or her request for review. The claimant will also be provided, upon request and free of charge, reasonable access to and the copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination. The review will be conducted by someone different from the original decision makers and

without deference to the original decision. The Plan Administrator shall notify the claimant of its decision within 60 days after receipt of the request for review. The decision shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based and a statement that the claimant is entitled to receive, free of charge, all relevant records, including internal rules, protocols or guidelines relied upon in making the decision.

## **ARTICLE 7 - AMENDMENTS TO PLAN**

By action of the Legislators, in accordance with its normal procedures, at any time or from time to time, may amend any or all of the provisions of the Plan. No amendment shall have the effect of modifying any Benefit Salary Redirection Agreement of any Participant in effect at the time of such amendment, unless such amendment is made to comply with federal, state, or local laws, statutes or regulations.

## **ARTICLE 8 - TERMINATION OF PLAN**

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time by action of the Legislators in accordance with its normal procedures.

In the event the Plan is terminated, no further contributions shall be made. Benefits under any insurance contract shall be paid in accordance with the terms of the contract.

No further additions shall be made to the Health Care Reimbursement and/or Dependent Care Assistance Accounts, but all payments from such fund(s) shall continue to be made according to the Salary Redirection Agreements in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims), or until the balances of all accounts have been reduced to zero, whichever occurs first. Any amounts remaining in any such fund(s) or account(s) as of the end of the Plan Year in which Plan termination occurs shall be forfeited and revert to the Employer after the expiration of the filing period.

## **ARTICLE 9 - MISCELLANEOUS**

### ***9.1 NO EMPLOYMENT RIGHTS CONFERRED***

The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Sponsor and any Participant or to be a consideration for, an inducement to, or condition of employment of any person. Nothing contained herein shall be construed to give a Participant the right to be retained in the employ of the Sponsor, to interfere with the right of the Sponsor to discharge a Participant at any time, to give to the Sponsor the right to require a Participant to remain in its employ, or to interfere with a Participant's right to terminate his employment with the Sponsor at any time. Any information obtained by the Sponsor with respect to claims submitted under the Plan shall be considered confidential and may not be used to dismiss or discipline an Employee.

### ***9.2 NO COMPENSATION FOR OTHER PURPOSES***

Benefits paid under the terms of the Plan shall not be treated as additional Compensation to the Participant for the purposes of determining contributions or benefits under any qualified retirement plan maintained by the Sponsor or for the purpose of any other benefit obligations of the Sponsor unless otherwise provided under the terms of the retirement plan or other benefit program.

**9.3 STATUS OF BENEFITS**

The Employer believes that this Plan is in compliance with § 125 of the Code and that it provides certain Benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

**9.4 IMPOSSIBILITY OF PERFORMANCE**

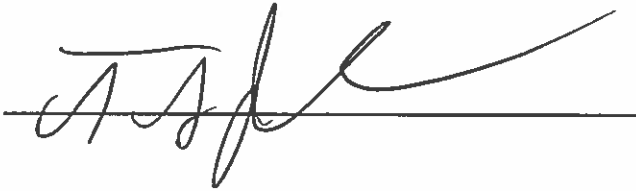
If it becomes impossible for the Sponsor to perform any act under the Plan, that act shall be performed which in the judgment of the Sponsor will most nearly carry out the intent and purposes of the Plan.

**9.5 GOVERNING LAW**

All legal questions pertaining to the Plan shall be determined in accordance with the laws of the State of New York except when those laws are preempted by the laws of the United States.

IN WITNESS WHEREOF, the CHEMUNG COUNTY has caused this instrument to be executed this day of May 9, 2018

**CHEMUNG COUNTY**

By: \_\_\_\_\_

## **Attachment A REVOCATION AND MODIFICATION OF ELECTIONS**

Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not amend or revoke his election of Benefits, unless there is a Change in Status or Change in Coverage. The revocation of a designation of Benefits and election of new Benefits may be made by an Eligible Employee only if both the revocation of existing designation of Benefits and election of new Benefits are made on account of and consistent with the Change in Status events listed below (except for coverage under COBRA as defined in Attachment B or similar state coverage).

### **A. CHANGE IN STATUS:**

1. A change in a Participant's legal marital status, including marriage, divorce, legal separation, annulment, or death of the Participant's spouse.
2. An event affecting the number of the Participant's Dependents, including birth, death, adoption, and placement for adoption.
3. A change in employment status of the Participant, his spouse or Dependents, including termination or commencement of employment (as determined under the Code § 125 regulations); a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or a change in the employment status of the Participant, his spouse or dependent (e.g. hourly to salary, union to non-union, or full-time to part-time), that affects that person's rights under this Plan or an underlying benefit program (e.g., changing from salaried to hourly-paid, union to non-union or part-time from full-time).
4. An event that causes a Participant's Dependent to satisfy or cease to satisfy the eligibility requirements for a particular benefit, such as attaining a specified age or the Dependent's status as a student.
5. A change in the residence of the Participant, his spouse or Dependent.
6. Any other events included under Code § 125, or regulations or other guidance promulgated thereunder relating the changes in status.

The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code § 125.

### **B. CHANGE IN COST/COVERAGE:**

The following sections DO NOT apply to Flexible Spending Accounts (FSA) or Unreimbursed Medical Accounts.

1. If benefit coverage under a Plan (see Attachment C) is significantly curtailed (as determined by the Plan Administrator in its sole discretion) or ceases during a Plan Year, the Participant may revoke his or her election under the Plan with respect to that coverage and may prospectively elect coverage under another plan that provides similar coverage. Coverage under a benefit plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general.
2. If during a Plan Year a Plan (see Attachment C) adds or eliminates a benefit, an affected Participant may elect a newly-added benefit, or elect another benefit where a benefit option has been eliminated, prospectively on a pre-tax basis by making corresponding election changes with respect to coverage with respect to the benefit option providing similar coverage.

3. A Participant may make a prospective election change that is on account of and corresponds with a change made under a plan of the employer of the Participant's spouse, former Spouse, of Dependent's employer, if (a) the cafeteria plan or benefit plan in which the Spouse, former Spouse, or Dependent participates permits its participants to make an election change that would be permitted under Treasury regulation § 1.125-4(b) through (g); or (b) the Participant's plan year period of coverage is different from the plan year period of coverage under the cafeteria plan or benefit plan of the plan in which the Spouse, former Spouse or Dependent participates.
4. If the Participant's share of the premium increases or decreases during a Plan Year by an insignificant amount, then the appropriate benefit elections of the Participant shall be prospectively increased or decreased to reflect such change. If the Participant's share of the premium increases significantly during a Plan Year, then the Participant may either make a corresponding prospective increase in his or her contributions or may revoke his or her election and in lieu thereof, receive coverage under another Plan option which provide similar coverage. Whether an increase or decrease in cost is significant or insignificant shall be determined by the Plan Administrator, on a reasonable and consistent basis, in accordance with prevailing IRS guidance, and based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).
5. Where there is a judgement, decree, or order (including a qualified medical child support order described in ERISA § 609) ("Order") resulting from a Participant's divorce, annulment, legal separation, or change in custody, (a) a Participant's election under an accident and health plan may be changed to provide coverage for a Dependent who is the Participant's child if the Order requires such coverage, and (b) coverage of the Dependent who is the Participant's child may be revoked or changed if the Order requires someone other than the Participant to provide such coverage.
6. If a Participant, his spouse, or Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under § 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the accident or health coverage of the person becoming entitled to Medicare or Medicaid. If a Participant, spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage.
7. If a Participant, his spouse, or Dependent becomes eligible for accident or health coverage under COBRA (as defined in Attachment B) or similar health plan continuation coverage under state law, then the Participant may increase his election to pay for such coverage.
8. If a Participant, his spouse, or Dependent is entitled to special enrollment rights under a group health plan, as required by Code § 9801(f) (i.e.HIPAA), then a Participant may revoke a prior election for coverage under a group health plan and make a new election, provided that the election corresponds with such special enrollment rights.
9. Where the Participant takes leave under the Family and Medical Leave Act of 1993, the provisions of Section 4.11 shall apply.

A Participant entitled to make a new election under Section 5.2 including Attachment A must do so within 30 days of the event described above. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event (described in Section 5.2 including Attachment A) occurs.

## **Attachment B COBRA Continuation Coverage**

You are receiving this notice because you have recently become covered under your Employers Flexible Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your flexible benefit plan coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Plan Document and Summary Plan Description.

The Plan Administrator is CHEMUNG COUNTY, 203-205 Lake St., ELMIRA , NY 14901. The Plan Administrator is responsible for administering COBRA continuation coverage.

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualifying beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, an employee may be a qualified beneficiary. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of either of the following qualifying events happens:

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

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiary. For each beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to the end of the current Plan Year.

### If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact your Department of Human Resources or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District 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

In order to protect your rights, you should keep the Plan Administrator informed of any changes in address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **Attachment B Notice of Privacy Practices**

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

Effective Date of Notice: April 14, 2004

Your Employer sponsored Health Reimbursement Arrangement is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosure of Protected Health Information (PHI); and
- Your privacy rights with respect to your PHI; and
- The Plan's duties with respect to your PHI; and
- Your right to file a complaint with the Plan and to the Secretary of the US Department of Health and Human Services; 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, electronic).

### **Section 1: Notice of PHI Uses and Disclosures**

#### **Required PHI Uses and Disclosures**

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

#### **Uses and Disclosure to Carry Out Treatment, Payment and Health Care Operations**

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan document to protect your PHI as required by federal law.

*Treatment* is the provision, coordination or management of health care and related services. 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 cardiologist the name of your treating family practice physician so the cardiologist may ask for your medical records from the treating family practice physician.

*Payment* includes but is not limited to actions to make coverage determinations and payment including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and 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 will be paid by the Plan.

*Health Care Operations* include but are not limited to quality assessment and improvement, reviewing competence or qualification of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

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 claim processing functions.

#### **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 when needed by the Plan to defend against litigation filed by you.

#### ***Uses and Disclosures that Require You be Given an Opportunity to Agree or Disagree Prior to Use or Release***

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

#### ***Uses and Disclosures for Which Consent, Authorization or Opportunity to Object is Not Required***

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- (1) When required by law.
- (2) When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- (3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may 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 that notice would cause a risk of serious harm. For the purpose 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 may generally 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.
- (4) The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in 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 government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- (5) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided 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 no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- (6) When required for law enforcement purposes (for example, to report certain types of wounds).
- (7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- (8) When required to be given 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.
- (9) The Plan may use or disclose PHI for research, subject to conditions.
- (10) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- (11) 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.

## ***Section 2: Rights of Individuals***

### **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 uses and 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 request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the Plan Administrator at the address listed in the Plan and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

### **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 the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan Administrator at the address listed in the Plan and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the US Department of Health and Human Services.

#### **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 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 with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the Plan Administrator at the address listed in the Plan and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

#### **The Right to Receive and Accounting of PHI Disclosures**

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However such accounting need not include PHI disclosures made (1) to carry our treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, 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.

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

To obtain a paper copy of this Notice contact the Plan Administrator at the address listed in the Plan and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

#### ***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 take one of the following forms:

- 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
- 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***

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.

This notice is effective beginning April 14, 2004, and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI. The Privacy Officer will send any revised versions to the Plan's Human Resources Department.

Any revised version of this notice will be distributed within 60 days of the effective date 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.

#### **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 the US Department of Health and Human services
- Uses or disclosures that are required by law and
- uses or disclosures that are required for the Plan's compliance with legal regulations

This notice does not apply to information that has been de-identified. De-identified information is 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.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or termination the group health plan, which 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 HIPAA.

#### ***The Plan Sponsor Agrees to Certain Conditions with Respect to PHI***

The Plan Sponsor agrees to:

- (1) not use or further disclose PHI other than as permitted or required by the plan document or a required by law;
- (2) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to
- (3) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- (4) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- (5) report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- (6) make PHI available to an individual in accordance with HIPAA's access requirements;

- (7) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (8) make available for information required to provide an accounting of disclosures;
- (9) make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for purposes of determining the Plan's compliance with HIPAA; and
- (10) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosure to those purposes that make the return or destruction infeasible).

#### ***Section 4: Disclosure through electronic media***

The Plan Administrator may furnish documents requested through electronic media to the Plan Participant as long as:

- (1) The administrator takes appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by participants of transmitted information and documents (i.e. uses return-receipt electronic mail feature or conducts periodic reviews or surveys to confirm receipt of transmitted information).
- (2) Electronically delivered documents are prepared and furnished in a manner consistent with the applicable style, format and content requirements.
- (3) Each participant is provided notice, through electronic means or in writing, apprising the participant of the document(s) to be furnished electronically, the significance of the documents (i.e. the document describes changes in the benefits provided by your plan) and the participant's right to request and receive, free of charge, a paper copy of each such document.
- (4) Upon request of any participant, the administrator furnishes, free of charge, a paper copy of any document delivered to the participant through electronic media.

The furnishing of documents through electronic media satisfies the requirements of this section only with respect to participants who:

- (1) Have the ability to effectively access, at their worksite, documents furnished in electronic form.
- (2) Have the opportunity, at their worksite location, to readily convert furnished documents from electronic form to paper form free of charge.

#### ***HIPPA Security Requirements Applicable to Electronic PHI***

Effective April 20, 2006, the Plan Sponsor will:

- (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (2) ensure that the adequate separation between the Plan and the Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures;
- (3) ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- (4) report to the Plan any security incident of which it becomes aware concerning electronic PHI.

#### ***Section 5: Your Right to File a Complaint with the Plan or HHS Secretary***

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator at the address listed in the Plan and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

You may file a complaint with the Secretary of the US Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

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

**Section 6: 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 Plan Administrator at the address listed in the Plan Document and Summary Plan Description or to the Privacy Officer, SIEBA, LTD., 111 Grant Ave., Suite 202, Endicott, NY 13760.

**Conclusion**

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

## Attachment C CURRENT PLANS

Following is a listing of the current Plan Documents for any Health Benefit Plans that have a premium contribution eligible to be deducted from Employees compensation on a pre-tax basis according to IRC 125 and your Flexible Benefit Program. Refer to the definition of "Health" in Article 2 Definitions.

PLAN NAME	PLAN #	EFFECTIVE DATE	TERM DATE
Excellus Classic Blue	00033682	1/1/00	
Excellus Blue PPO	00033682	7/1/03	
Excellus Blue PPO 2	00033682	1/1/18	
Excellus Prescription Plan	00033682	1/1/06	
Lifetime Benefit Solutions-Dental	JCH08	1/1/00	
Lifetime Benefit Solutions-Vision	JCH08	1/1/00	
CSEA Platinum 12-Vision	OR405 OZ411	1/1/97 3/1/97	

Please contact your Employer for a copy of the above Plan Document(s).