

**SAMPLE PLAN**

[\_\_\_\_\_ Presbyterian Church (U.S.A.)]

**Health Flexible Spending Plan**

(Describing health care expense reimbursement benefits  
available to employees)

Effective [\_\_\_\_\_]

## LEGAL DISCLAIMER

### (A few words from our lawyers)

This sample plan document has been prepared by The Board of Pensions of the Presbyterian Church (U.S.A.) as part of an information kit about Health Flexible Spending Plans for the employing organizations of the Presbyterian Church (U.S.A.)

In producing a ‘sample plan’, the Board of Pensions intends only to supply employing organizations with a sample of the documentation that an employing organization needs to prepare when adopting such a program. The Board is not permitted to provide legal or tax advice to employing organizations and the sample plan is not intended to substitute for the advice of your legal or tax counsel. **If your organization elects to adopt such a plan, it must prepare and adopt its own plan document with the advice of its own legal and tax counsel.**

In designing a flexible spending plan, an employing organization must make a number of decisions about the form of the benefit to be offered and certain administrative practices. First and foremost, this sample plan document only provides for reimbursement of health care expenses. An employing organization may elect to offer a dependent care flexible spending plan or other form of cafeteria plan to make additional benefits available to the employees. Such programs will require separate plan documents. A number of provisions in this “sample plan” include a suggested default option that is fairly simple to administer. The default option may not be the most advantageous to employees or the least risky to the employing organization. The default provisions that were selected by the Board in drafting this “sample plan” are listed below. **Each employing organization must make its own decisions about the plan design provisions before it prepares and adopts a final plan document. The kit’s employee plan summary and related forms must also be customized to your plan before printing and distributing to your employees.**

Coverage under a plan must be provided for a full 12-month period (referred to in the sample plan as the “plan year”). However, if an employing organization wishes to adopt a plan in the middle of a plan year, it may do so, provided that coverage is available for the entire short plan year. For example, if a plan uses the calendar year as a plan year, but the plan is adopted July 1, the full amount of coverage elected by eligible employees must be available from July 1 through December 31. The employing organization might consider using a reduced annual limit (see Section 4.04 of the sample plan) for the initial short plan year.

The tax benefits of a Health Flexible Spending Plan are contingent upon compliance with the technical and operational compliance requirements of the Internal Revenue Code and the Department of Treasury and Internal Revenue Service regulations, rulings and interpretations. In recent years, these legal requirements have been modified several times. **If your organization adopts a Health Flexible Spending Plan, it is the responsibility of the organization to keep current with the law and regulations governing such plans and to administer it in accordance with all applicable laws and regulations. The Board of Pensions does not assume legal responsibility for these plans and shall not be responsible for your plan or its operation.**

Each employing organization should review the sample plan provisions, particularly the following default provisions, to determine the applicability of the terms to its organization. The plan document should be customized for each organization's needs.

- Eligibility (Section 2.01). The sample plan provides that all employees who are regularly scheduled to work a minimum number of hours per week (20, 30, etc.) are eligible after an initial waiting period (30 days, 3 months, etc.). The provision could be revised to cover only a particular class of employees (*e.g.*, salaried or hourly). Also, the minimum hours requirement and/or the initial waiting period could be eliminated.
- Default Coverage (Section 2.03). The sample plan provides that eligible employees must affirmatively elect coverage each year. Alternatively, the plan could use a negative election – each year (other than the first year) the coverage election would default to the previous year's election unless the eligible employee affirmatively makes a change.
- Coverage Following Severance (Section 3.02). Under the sample plan, coverage is not available if an individual is receiving severance. This provision could be revised to allow coverage if permitted under the severance agreement.
- Leaves of Absence (Section 3.03). The sample plan permits employees who take unpaid leaves of absence to continue coverage during the leave by making contributions on an after-tax basis, assuming the continued coverage is consistent with the employing organization's personnel policies. Alternatively, this provision could prohibit coverage during an unpaid leave (which would eliminate the administrative burden of processing after-tax contributions).
- Continuation Coverage (Section 3.04). The sample plan provides that continuation coverage, which is a type of "bridge" coverage provided after an employee ceases to be eligible, is available only to the extent it is offered under the employing organization's health benefits plan. Continuation coverage is not required to be offered.
- Inclusion of Grace Period following end of Plan Year to incur and be reimbursed for expenses (Definition of "Grace Period," Sections 4.01-4.03, 4.05). The sample plan includes a 2½ month grace period. By including the grace period, the plan allows a plan participant who has unused amounts from the immediately preceding plan year, and who incurs eligible expenses during the grace period, to be paid or reimbursed for those eligible expenses from the unused amounts as if the expenses had been incurred in the immediately preceding plan year. After the grace period expires, unused amounts will be forfeited under the "use-it-or-lose-it" rule. An employer need not adopt a grace period and may require participants to incur all eligible expenses in the calendar year.
- Annual Limits (Section 4.04). The sample plan imposes a dollar limit on the amount of coverage an eligible employee may elect each year. Keep in mind that the full amount of coverage is available as of the first day of the year. For example, if an eligible employee elects \$3,000 of coverage for 2004, and incurs \$2,900 in claims on January 2, 2004, the plan must pay the \$2,900 even if the employee terminates employment during 2004.

before he contributes the full \$3,000 to the plan. The employing organization is responsible for the shortfall.

- Expense Reimbursement Procedure (Section 4.05). The sample plan requires that claims must be submitted to the claims administrator within 90 days after expenses are incurred (or billed, if later). Shorter or longer claims periods are permissible.
- Administration of the Plan (Section 6.01). The sample plan provides that the employing organization is legally responsible for administering the plan and is treated as a fiduciary of the plan. The employing organization may delegate some or all of its administration duties to a person or committee.
- HIPAA Privacy and Security Practices (Article VIII). A flexible spending plan is a covered entity under the administrative simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The sample plan includes plan provisions necessary to implement the federal health care privacy and security standards under HIPAA. These provisions permit the employing organization, as plan sponsor, to receive individually identifiable health information from the plan for purposes of plan administration. The employing organization should confirm that its internal practices are consistent with these provisions and the HIPAA privacy rules. In addition to the privacy regulations, there are two other regulations under HIPAA that apply to a health plan such as a flexible spending plan. These regulations mandate the use of uniform electronic transactions for health claims and other related financial transaction between health care providers and payors and the implementation of certain technical, physical and administrative security standards for electronic data maintained by health plans.

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An "\*" by a section indicates that the section includes a default provision discussed in the Legal Disclaimer section.

## INTRODUCTION

The [\_\_\_\_\_] Health Flexible Spending Plan (the "Plan") was established to provide for the reimbursement of certain health care expenses to the eligible employees of [\_\_\_\_\_] Presbyterian Church (U.S.A.) ("Employer") . This document constitutes the Plan, effective as of [\_\_\_\_\_].

This Plan provides solely for the for reimbursement of Health Care expenses.

Employer reserves the right to alter, amend, modify or terminate the Plan in whole or in part, at any time for any reason in a manner consistent with the provisions of Article VII.

This Plan is sponsored by a church organization and is intended to be a church plan as defined in Section 414(e) of the Internal Revenue Code, as amended ("Code") that has not made an election under Section 410(d) of the Code and is therefore exempt from the requirements of the Employment Retirement Income Security Act of 1974 generally applicable to such plans.

This Plan is intended to qualify as an "accident and health plan" within the meaning of section 105(e) of the Code and any other pertinent laws or regulations, so that the benefits provided under the Plan shall be eligible for exclusion from each Employee's income for federal income tax purposes under section 105(b) of the Code. The provisions of this Plan shall be interpreted in accordance with that intent.

This document, as it may be duly amended, shall constitute the Plan in its entirety. In the event any discrepancies exist between this document and any amendment, the amendment shall govern.

## ARTICLE I

### DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated hereto or amendment hereto, have the meanings set forth below. Words in the masculine gender include the feminine gender, and vice versa. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

#### Annual Enrollment Period

Annual Enrollment Period means the period of time preceding the beginning of each Plan Year during which Participants may elect coverage under the Plan.

#### Benefits Plan

Benefits Plan means the Benefits Plan of the Presbyterian Church (U.S.A.) administered by the Board of Pensions of the Presbyterian Church (U.S.A.)

#### Claim Administrator

Claim Administrator means the person, persons, entity or entities appointed by the Employer, who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms.

#### COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Church plans are exempt from certain COBRA requirements applicable to medical or cafeteria plans. The Benefits Plan provides for medical continuation coverage that is comparable to COBRA coverage.

#### Code

Code means the Internal Revenue Code of 1986, as amended from time to time.

#### Dependent

Dependent means an Employee's spouse and any individual who is a dependent of the Employee within the meaning of section 152 of the Code, as modified by statute, regulation, or otherwise.

Effective Date

Effective Date means [\_\_\_\_\_]. The Effective Date of any amendment or restatement is the effective date specified in the amendment or restatement.

Eligible Employee

Eligible Employee means an individual who is an Eligible Employee with the meaning of the Section 2.01.

Employer

Employer means [\_\_\_\_\_] Presbyterian Church (U.S.A.).

Enrollment Form

Enrollment Form means a form prescribed by the Plan Administrator for purposes of enrolling for coverage under the Plan or for changing or waiving such coverage, including any applicable compensation reduction agreement relating to this Plan.

\*Grace Period

Grace Period means the period of time immediately following the end of a Plan Year, beginning on the day after the end of the Plan Year and ending on the fifteenth day of the third calendar month after the end of the Plan Year.

Health Care Expense

Health Care Expense means any amount Incurred that is an expense for medical care within the meaning of section 105(b) of the Code, excluding expenses reimbursed by any other health care plan, premiums paid for any other health care coverage and other expenses for which coverage under this Plan is proscribed by the Code or other applicable law. The Employer shall determine whether any other amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Incurred

Incurred means the date health care services or supplies were provided. Health Care Expenses are Incurred as of the date they are provided and not the date they are formally billed or charged or the date they are paid.

### Participant

Participant means any Eligible Employee who meets the requirements for participation under this Plan and for whom coverage is in effect under this Plan or an individual who has elected continuation coverage under Section 3.04 and for whom coverage is in effect under this Plan.

### Plan

Plan means the [\_\_\_\_\_] Health Flexible Spending Plan, as described herein and as amended from time to time.

### Plan Administrator

Plan Administrator means the person, persons or committee identified to serve as Plan Administrator in Section 6.01.

### Plan Year

Plan Year means the period beginning [\_\_\_\_\_] and ending [\_\_\_\_\_] or a 12-consecutive-month period beginning on any [\_\_\_\_\_] thereafter.

### Prior Coverage

Prior coverage means coverage under a group health plan or health insurance coverage that is subject to the requirements of HIPAA, other than coverage under a plan maintained by the Employer.

### Qualifying Change in Status

Qualifying Change in Status means, as determined by the Plan Administrator, subject to any restriction under applicable law, the occurrence of one of the following events:

- (a) an event that changes Eligible Employee's legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;
- (b) an event that changes the number of an Eligible Employee's Dependents, including birth of a child, adoption, placement for adoption or death of a Dependent;
- (c) a termination or commencement of employment, a commencement of or a return from a leave of absence, or a change in worksite of an Eligible Employee, spouse of an Eligible Employee, or Dependent of an Eligible Employee;
- (d) a change in employment status of an Eligible Employee, spouse of an Eligible Employee, or Dependent of an Eligible Employee that causes the individual to become or cease to be eligible for this Plan;

- (e) an event that causes the eligibility of an Eligible Employee's Dependent for coverage under this Plan to change, including attainment of age or termination of student status;
- (f) a change in the residence or worksite of an Eligible Employee, spouse of an Eligible Employee, or Dependent of an Eligible Employee; or
- (g) another change that is determined by the Plan Administrator, consistent with the rules under section 125 of the Code and the regulations promulgated thereunder, to be an occurrence in the life or work of an Eligible Employee, his spouse, or any of his Dependents that would permit the Eligible Employee to elect, waive, or change coverage under this Plan during the Plan Year, including certain changes in benefits coverage for the Eligible Employee, spouse of the Eligible Employee or Dependent of the Eligible Employee including the elimination of coverage, loss of availability of coverage, substantial decrease in coverage (including material changes in availability of in-network providers) or other similar fundamental loss of coverage as determined by the Plan Administrator.

#### Special Enrollment Event

Special Enrollment Event means, with respect to any Eligible Employee and any Benefit under a health benefit plan subject to the special enrollment provisions of HIPAA, as amended:

- (a) the marriage of the Eligible Employee;
- (b) the birth, adoption, or placement for adoption of a child of the Eligible Employee; or
- (c) the qualifying loss of prior health care coverage by the Eligible Employee or a Dependent, so long as a statement is submitted to the Plan Administrator to such effect in accordance with the rules established by the Plan Administrator. For purposes of this definition, qualifying loss means:
  - (i) if the prior coverage is provided under COBRA or Benefits Plan medical continuation coverage, the exhaustion of such coverage; or
  - (ii) if the prior coverage is not described in Section (c), the loss of eligibility for such coverage or the termination of employer contributions toward the prior coverage.

## ARTICLE II

### ELIGIBILITY AND ENROLLMENT

#### \*2.01 Eligibility

Individuals shall become eligible to participate in the Plan as follows:

- (a) An individual who was an actively employed employee (including a minister of the Word and Sacrament) on the day before the Effective Date, shall be eligible to participate in this Plan beginning on the Effective Date.
- (b) Each newly hired or reemployed active employee regularly scheduled to work at least [ ] hours per week shall be eligible to participate in the Plan as of the [ ] day after the commencement of employment.
- (c) The term “Eligible Employee” does not include any Employee who performs service for the Employer as a leased employee within the meaning of Code Section 414(n) or 414(o), nor an Employee who is an in-house temporary employee.
- (d) No Eligible Employee shall become a Participant unless the Eligible Employee enrolls in accordance with the rules set forth in Section 2.02.

#### 2.02 Enrollment

An Eligible Employee may elect, waive or change coverage under this Plan in accordance with and only in accordance with the provisions of this Section.

##### (a) Initial Enrollment

An individual who is newly eligible to participate in the Plan must complete an Enrollment Form to enroll in the Plan and commence participation in the Plan. Such Enrollment Form must be completed, executed, and returned to the Plan Administrator no later than 30 days after the individual has received the Enrollment Forms. Such coverage will be effective as soon as administratively possible, but no later than 30 days after the completed Enrollment Form is received by the Plan. If the Plan Administrator does not receive a properly completed Enrollment Form by the day of the applicable time period, the Eligible Employee shall not be covered under the Plan.

##### (b) Annual Enrollment Period

During the Annual Enrollment Period, an Eligible Employee may enroll for, waive, or change coverage, or modify the rate of his contributions by submitting a

properly completed Enrollment Form. Such new election shall be effective as soon as administratively possible, but no later than 30 days following the Annual Enrollment Period. If the Plan Administrator does not receive a properly completed Enrollment Form by the end of the Annual Enrollment Period, the Eligible Employee shall not be covered under the Plan.

(c) Qualifying Change in Status

- (i) Subject to any provisions set forth in this Plan, an Eligible Employee shall be permitted to change coverage under this Plan during a Plan Year upon a Qualifying Change in Status.
- (ii) If an Eligible Employee experiences a Qualifying Change in Status and the Eligible Employee completes, executes, and returns to the Plan Administrator an Enrollment Form within 30 days after the date of the event, the Eligible Employee may enroll for, waive, or change his coverage provided that such election is consistent with the Eligible Employee's Qualifying Change in Status and the terms of this Plan. The election shall be effective as of the date the properly completed Enrollment Form is received by the Employer.
- (iii) There is no limit to the number of Qualifying Changes in Status that can occur during a Plan Year.
- (iv) The Plan Administrator shall make all determinations as to whether a Qualifying Change in Status has occurred and whether a requested change in coverage is consistent with a Qualifying Change in Status. For purposes of making such a determination, the Plan Administrator may require an Eligible Employee to submit evidence that the Eligible Employee has incurred a Qualifying Change in Status and such other evidence as the Plan Administrator deems reasonable under the circumstances.

(d) Special Enrollment Rules

An Eligible Employee may elect to enroll for coverage when a Special Enrollment Event occurs in accordance with the rules specified under the Benefits Plan.

(e) Other Mid-Year Change Events

- (i) If an Eligible Employee or Dependent of an Eligible Employee becomes entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under section 1928 of such Act, the Eligible Employee may change his or her election to cancel or decrease contributions.
- (ii) If an Eligible Employee or Dependent of an Eligible Employee who is entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid)

of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under 1928 of such Act, loses eligibility for such coverage, the Eligible Employee may elect to commence or increase contributions.

(f) Any change made under this Section shall be effective prospectively only.

\*2.03 Default Coverage

In the event of a failure to elect coverage, the following rules shall apply:

- (a) If a new Eligible Employee fails to submit a properly completed Enrollment Form by the date specified in Section 2.02(a), the Eligible Employee shall be deemed to waive coverage under the Plan for the balance of the Plan Year.
- (b) If an Eligible Employee fails to submit a properly completed Enrollment Form or to elect coverage under this Plan by the end of the Annual Enrollment Period for a Plan Year, the Eligible Employee shall be deemed to waive coverage under this Plan for that Plan Year.

In either case (a) or (b), the Eligible Employee shall be permitted to enroll for coverage in accordance with Section 2.02(b) during the next Annual Enrollment Period or in accordance with Section 2.02(c) following a Qualifying Change in Status.

Coverage provided by default under this section shall, for all purposes under the Plan, be treated as if it had been elected by an Eligible Employee.

2.04 Enrollment Forms

Subject to Section 6.03(h), no election by an Eligible Employee with regard to enrollment for coverage, a change in coverage, or the waiver of coverage shall be effective unless the election is made in writing on the prescribed Enrollment Form and the form is timely filed with the Plan Administrator.

## ARTICLE III

### TERMINATION OF BENEFITS

#### \*3.01 Termination Date of Coverage

An individual's participation in the Plan shall terminate as of the earliest of:

- (a) the date of termination of this Plan;
- (b) the date as of which this Plan is amended to terminate benefits with respect to a classification of Employees of which the individual is a member;
- (c) the date as of which the individual fails to make any contribution required under this Plan for coverage when due;
- (d) the date as of which the individual elects to waive coverage under this Plan, provided that the election is made in accordance with the rules of Article II;
- (e) the date as of which the individual dies, retires or otherwise ceases to be an Eligible Employee; or
- (f) the date as of which the individual enters the armed forces of any country on active, full-time duty, subject to any right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, as such Act may be amended from time to time or

An individual whose coverage ceases under this Section, other than an individual who continues coverage pursuant to an election under Section 3.04, shall be entitled to reimbursements under the Plan for Health Care Expenses incurred prior to the date of such cessation in an amount that does not exceed the lesser of: (i) the individual's Health Care Expenses Incurred during the portion of such Plan Year in which he is a Participant; or (ii) the annual amount elected under the Plan for the reimbursement of Health Care Expenses (less reimbursable Health Care Expenses that were Incurred in the Plan Year, while the individual was a Participant, and that have previously been reimbursed). However, if in the course of the Plan Year in which the individual's participation ceases, the individual resumes participation in the Plan, with respect to Health Care Expenses Incurred after the date of such resumption; the annual amount elected by the individual for the Plan Year shall reflect that no contributions were made during the period when the individual was not a Participant, except as otherwise required by Section 3.02.

If, as a result of a Qualifying Change in Status, an individual who has been a Participant during a Plan Year elects to reduce his coverage under the Plan below the level most recently in effect, to the extent the change in election causes the total amount elected for the Plan Year to be less than the Health Care Expenses of the Individual for the Plan Year

or increases the amount by which such Health Care Expenses exceed such elected amount, the following rules shall apply:

- (a) To the extent the Health Care Expenses have already been reimbursed, the election to reduce coverage shall not be effective;
- (b) To the extent the Health Care Expenses have been Incurred, but not yet reimbursed or have not yet been Incurred, they shall not be reimbursed;
- (c) In making the election to reduce coverage, the individual shall be deemed to acknowledge and accept the consequences of the reduction set forth in (a) and (b), above.

\*3.02 Coverage Following Severance

Coverage for an individual shall cease during a period for which the individual is entitled to severance benefits from his Employer.

\*3.03 Leaves of Absence

- (a) An Eligible Employee who takes an unpaid leave of absence from his Employer shall continue to be an Eligible Employee to the extent and only to the extent provided in the personnel policies and practices of the Employer or elsewhere in this Plan.

An Employee who is eligible to continue Plan participation during an unpaid leave of absence may elect to: (a) continue Plan participation during this period by making after-tax contributions to the Plan, thereby continuing coverage; or (b) cease Plan participation during the leave period.

If the Employee elects to continue Plan participation during the leave period, the Employee shall pay his contributions on an after-tax basis during the leave period according to the same payment schedule that applied immediately prior to his leave period. The Employee shall remit contributions to the Employer on a timely basis during the leave period. While coverage under the Plan is continued during the Employee's leave period, the full amount of elected coverage under the Plan shall be made available to the Employee at all times, including during the period of leave. If the Employee fails to make timely payment of contributions during the leave period, his coverage under the Plan shall cease and he may not be reimbursed for claims Incurred during the remainder of the leave period.

If the Employee elects to terminate coverage under the Plan during the period of leave, the Employee shall not be reimbursed for claims Incurred during the leave period. Upon the Employee's return to employment, his pre-leave coverage shall be reinstated automatically. Upon reinstatement, the Employee may elect to: (a) resume pre-leave coverage levels and make up the full amount of payments missed during leave; or (b) resume coverage at a level prorated to account for the period of leave and pay his contribution amounts at the level in effect prior to the

leave period. Upon reinstatement, coverage shall be reduced by the amount of reimbursements for claims Incurred prior to the period of leave.

- (b) An Eligible Employee who takes a paid leave of absence from his Employer shall continue to be an Eligible Employee hereunder and shall continue to participate during his leave of absence on the same basis, subject to the same terms and conditions, as he had participated immediately prior to his period of absence.

#### 3.04 Continuation Coverage

Eligible Employees shall be entitled to elect to continue coverage under this Plan in accordance with the rules established in the Benefits Plan, and any notices or other communications furnished by the Employer thereunder. Such coverage shall be provided only as required, and such coverage shall cease as soon as, and the premiums or dues shall be as great as, permitted by applicable law and the regulations promulgated thereunder.

## ARTICLE IV

### BENEFITS, FUNDING, AND CONTRIBUTIONS

#### \*4.01 Provision of Benefits

The benefits available under this Plan for a Plan Year shall take the form of reimbursement for Health Care Expenses Incurred during the Plan Year and the ensuing Grace Period. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses Incurred after his participation has commenced and before his participation has ceased.

#### \*4.02 Amount of Reimbursement

At all times during the Plan Year and the ensuing Grace Period a Participant shall be entitled to reimbursement under this Plan in an amount that does not exceed the anticipated amount to be allocated on his behalf under the Plan (or under his election under Section 3.05) for payment of Health Care Expenses under the Plan for the Plan Year (less any previously reimbursed Health Care Expenses), regardless of the actual amount then standing to the Participant's credit under the Plan for payment of Health Care Expenses. Each payment hereunder shall be a charge against the amount available to pay Health Care Expenses under the Plan.

#### \*4.03 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement under this Plan for any Plan Year shall be limited to the smallest of the following:

- (a) the Participant's Health Care Expenses for the Plan Year and the ensuing Grace Period;
- (b) the amount elected by the Participant for the payment of Health Care Expenses under the Plan for the Plan Year (less any previously reimbursed Health Care Expenses); or
- (c) the annual maximum amount described in Section 4.04.
- (d) any limitation established with respect to the Participant pursuant to Section 4.06 or 8.02.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

To the extent the amount of contributions credited to a Participant's account for a Plan Year pursuant to his compensation reduction agreement and election of coverage under

this Plan exceeds his Health Care Expenses appropriately submitted for reimbursement for a Plan Year and the ensuing Grace Period, the amounts credited to his account shall be forfeited and applied toward administrative expenses under the Plan.

Expenses Incurred during the Grace Period shall be allocated either to the previous Plan Year, or the Plan Year in which the Grace Period occurs, in accordance with administrative rules established by the Employer with regard to the Grace Period.

\*4.04 Annual Limits

The annual maximum amount that a Participant may elect for the reimbursement of Health Care Expenses under the Plan for any Plan Year shall be [\$\_\_\_\_\_\_] or such other amount that the Employer shall prescribe and communicate to Participants. The minimum amount that a Participant may allocate for the reimbursement of Health Care Expenses under the Plan for any Plan Year shall be [\$\_\_\_\_\_\_] or such other amount that the Employer shall prescribe and communicate to Participants.

\*4.05 Expense Reimbursement Procedure

Reimbursement of Health Care Expenses shall be made in accordance with the following rules:

- (a) To receive reimbursement for Health Care Expenses under this Plan, a Participant must submit a written application to the Claim Administrator not later than April 15 of the Plan Year following the Plan Year in which such Health Care Expenses were Incurred or billed to the Participant, in accordance with such rules, practices and procedures as the Claim Administrator may specify, in its discretion, for the reimbursement of Health Care Expenses under the Plan, including rules that do not invalidate an application that is submitted after April 15 provided the application is filed as soon as reasonably possible.
- (b) The Claim Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement.

Each request for reimbursement shall include such substantiation as required by the Claim Administrator, which may include the following information:

- (i) the name, Social Security number, and address of the employee;
- (ii) the name and date of birth of the person for whom the Health Care Expense was Incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;
- (iii) the name and address of the person, organization or other provider to whom the Health Care Expense was or is to be paid;

- (iv) a written statement from an independent third party setting forth the type, purpose, date and amount of the Health Care Expense for which reimbursement is requested; and
- (v) a statement that the Participant has not been reimbursed nor is reimbursable for the Health Care Expense by insurance or otherwise, and that the Participant has not been allowed a deduction for such Health Care Expense under section 213 of the Code.

The Claim Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Plan. The Claim Administrator may require the Participant to provide written authorization to obtain information from the Benefits Plan, any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his Dependents are enrolled.

- (c) Expenses eligible for coverage under the Benefits Plan, any group medical, HMO, dental, vision care, prescription drug, or other health plans in which the Participant or his Dependents are enrolled must be submitted first to all appropriate claim administrators for such plans in accordance with the rules of those plans, and be finally adjudicated under those plans, before submitting the expenses to the Employer for reimbursement under the Plan.
- (d) Subject to applicable law, the Employer may establish such rules as it deems desirable regarding the frequency of reimbursement of Health Care Expenses and the minimum dollar amount that may be requested for reimbursement.

#### 4.06 Contributions and Funding

- (a) Reimbursements for Health Care Expenses shall be financed out of contributions made by the Employer pursuant to Participants' compensation reduction agreements under the Plan.
- (b) The amount that the Employer contributes, if any, based on Participant's compensation reduction agreement shall be in addition to other amounts that the Employer, in its sole discretion, decided to contribute toward the cost of the Plan. Such contributions shall be credited to the Participants' accounts, as applicable.
- (c) Employer is not required by law to maintain, and does not maintain, actual separate and discrete accounts for Participants under this Plan. All payments shall be made from the general assets of the Employer, and no assets shall be earmarked or segregated for purposes of providing benefits.

- (d) The Employer may establish rules in addition to those already prescribed hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis.

## ARTICLE V

### PAYMENT OF BENEFITS

#### 5.01 Application for Benefits

To be entitled to payment of any benefits, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, the completion and filing of a written application and the provision of information, as described in Section 4.05.

#### 5.02 Assignment of Benefits

Except to the extent provided in this Plan, no benefit payable at any time under this Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator and the Employer.

#### 5.03 Payment to Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator, the Claim Administrator and the Employer.

#### 5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Health Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Health Care Expense shall completely discharge all liability of this Plan, the Claim Administrator, the Plan Administrator and the Employer with respect to such expense.

#### 5.05 Overpayments

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Health Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable

under the Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

#### 5.06 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Claim Administrator, the Plan Administrator and the Employer shall have no obligation or duty to locate a Participant. In the event a Participant becomes entitled to payment under this Plan and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without any consideration to interest payments which may have accrued.

#### 5.07 Missing Person

If, within two years after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

#### 5.08 Fraudulent Claims

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, the Plan Administrator may without anyone's consent terminate coverage, and the Claim Administrator may refuse to honor any claim under the Plan.

## ARTICLE VI

### ADMINISTRATION OF THE PLAN

#### \*6.01 Administration of the Plan

The Employer shall serve as Plan Administrator responsible for the administration of the Plan and shall be a named fiduciary of this Plan and shall make all determinations under the eligibility provisions set forth in Article II of the Plan. The Employer, acting as a named fiduciary or as Plan Administrator, may assign or delegate any of its responsibilities for administering this Plan or carrying out its provisions. To the extent of any such assignment or delegation, the assignee or delegate shall have all of the authority and powers of the Employer. Any action taken by the Employer assigning any of its responsibilities as Plan Administrator to specific persons who are directors, officers, or employees of the Employer shall not constitute delegation of the Employer's responsibility, but rather shall be treated as the manner in which the Plan Administrator (on behalf of the Employer) has determined internally to discharge such responsibilities.

#### 6.02 Appointment of Claim Administrator

The Employer may appoint one or more Claim Administrators to process all or a designated portion of claims under this Plan in accordance with its terms. The person, persons, entity or entities serving as Claim Administrator shall serve at the pleasure of the Employer. Each Claim Administrator shall have the authority and discretion to interpret the Plan with respect to its duties and to decide questions and disputes arising under the Plan with respect to such duties, which interpretations and decisions shall be final and binding for purposes of the Plan, subject to any right of Participants to appeal the interpretation and decisions under this Plan.

#### 6.03 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

- (a) to make claim decisions and benefit payments or direct the Claim Administrator to process all or a designated portion of claims and to make benefit payments to or on behalf of Participants entitled to benefits under this Plan;
- (b) to have the authority and discretion to interpret the Plan, to decide questions and disputes, to supply omissions, to correct defects, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;
- (c) to authorize its agents to execute or deliver any instrument or make payments on the Plan Administrator's behalf;

- (d) to obtain from Participants and others, such information as shall be necessary for the proper administration of this Plan, such as proof of other coverage and financial data needed to determine if an individual qualifies as the Dependent of an Employee (e.g., income tax returns);
- (e) to appoint committees with such authority and powers as the Plan Administrator deems necessary;
- (f) to retain counsel, employ agents, and provide for such clerical, accounting, actuarial, consulting, claims processing, and other services as it deems necessary or desirable to assist it in the administration of this Plan;
- (g) to retain the right, authority, and discretion to make claim payment and benefit decisions upon appeal to the extent it has the authority to make such appeal determinations under Section 6.04;
- (h) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any election or other submission requiring a written form may be made telephonically or electronically and whereby elections or submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;
- (i) to adopt rules for the administration of the Plan; and
- (j) to maintain records of administration of the Plan.

No determination of the Plan Administrator or the Claim Administrator in one case shall create a bias or retroactive adjustment in any other case. Expenses for the administration of the Plan shall be paid out of forfeitures under the Plan.

#### 6.04 Claims Procedure

The Claim Administrator shall review claims for benefits under this Plan and respond thereto within 30 days after receiving the claim. This period may be extended one time for up to 15 days. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification setting forth:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to pertinent Plan provisions upon which the denial is based;
- (c) a description of any additional material or information necessary for the claimant to perfect the claim;

- (d) if an internal rule, guideline or protocol was relied upon in making the determination, a copy of the rule, guideline or protocol or a statement that it will be provided free of charge upon request; and
- (e) an explanation of the claim review procedure set forth below.

The claimant or his duly authorized representative may request a full and fair review of the claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator.

The review of a claim by the Plan Administrator shall be subject to the following rules. The claimant or his duly authorized representative may review pertinent documents and may submit issues and comments, including without limitation appropriate evidence or testimony of an expert, in writing. The review will not afford deference to the initial adverse benefit determination. The review will not be conducted by the individual who made the adverse benefit determination or by that individual's subordinate. The Plan Administrator shall make a decision promptly, and not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, and specific references to the pertinent Plan provisions on which the decision is based.

In the event that the Claim Administrator or Plan Administrator does not make a determination with respect to a claim within the time limit prescribed by this Section, the claim or appeal of such claim decision shall be deemed denied.

#### 6.05 Records and Reports

The Claim Administrator and Plan Administrator shall maintain all such books, accounts, records and other data as may be necessary for the proper administration of this Plan.

The Plan Administrator shall make available to each Participant for examination at reasonable times during normal business hours such records under the Plan in its possession as pertain to him.

#### 6.06 Coordination with Other Benefits Plan

To the extent necessary or appropriate, the Plan Administrator shall coordinate its authority and responsibility with the plan administrator or administrators of any other benefits plan sponsored by Employer in accordance with such rules as the Plan Administrator and such other plan administrator or administrators shall determine.

#### 6.07 Fiduciary Duty and Care

All fiduciaries under this Plan, including the Claim Administrator and the Plan Administrator, shall discharge their respective fiduciary responsibilities solely in the interest of the Participants of this Plan for the exclusive purpose of providing benefits to

Participants and defraying the reasonable expenses of administering this Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and in accordance with the provisions of this Plan.

6.08 Limitation on Liability

A Plan fiduciary shall be entitled to rely upon information from any source assumed reasonably and in good faith to be correct. The Employer, Plan Administrator and Claims Administrator shall not be subject to any liability with respect to his duties under this Plan unless it acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

6.09 Indemnification

To the extent permitted by law, the Employer shall indemnify and hold harmless each director, officer, or employee of the Employer to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under this Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent. The Employer may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any fiduciary responsibility with respect to this Plan from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under this Plan.

## ARTICLE VII

### DURATION AND AMENDMENT OF THE PLAN

#### 7.01 Right to Amend

The Employer reserves the right to amend the Plan at any time, in any manner, including, without limitation, the right to amend the Plan to reduce, add to or modify the type and amount of benefits provided for any and all Participants. Any amendment shall be formally adopted in writing. The Employer reserves the right to delegate this authority to amend, in whole or in part, to any committee, office, officer, or other person or persons as it deems appropriate.

#### 7.02 Right to Terminate

Although the Employer intends to maintain this Plan for an indefinite period, the Employer reserves the absolute right to terminate or partially terminate the Plan at any time, for any reason by or pursuant to a resolution of the board of directors of Employer. Any termination or partial termination of the Plan shall not adversely affect the payment of benefits to which a Participant was entitled under the Plan prior to the date of termination or partial termination. If the Plan is terminated, each Participant shall be entitled to benefits for Health Care Expenses Incurred prior to the date of termination, provided that the Participant appropriately follows the terms of this Plan for reimbursement. Thereafter, the Employer shall have no liability or obligation to make any reimbursements under the Plan.

## ARTICLE VIII

### HIPAA PRIVACY AND SECURITY PRACTICES

#### 8.01 Purpose

The provisions of this Article are intended to comply with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, "HIPAA"). The provisions of this Article address provisions of HIPAA that govern the privacy of Protected Health Information ("PHI") as such provisions are set forth in 45 C.F.R. Subtitle A, Part 160 and Part 164, Subparts A and E (the "Privacy Rule"). The provisions of this Article also address provisions of HIPAA that govern the security of PHI, as such provisions are set forth in 45 C.F.R. Subtitle A, Part 160 and Part 164, Subparts A and C (the "Security Rule").

## 8.02 Inconsistent Provisions

This Article shall supersede any provisions of the Plan to the extent those provisions are inconsistent with this Article.

## 8.03 Definitions

Each capitalized term used in this Article that is not otherwise defined in the Plan shall have the meaning ascribed to it under HIPAA. For purposes of this Article, the following terms shall have the following meanings:

- (a) Covered Individual means an individual enrolled in and covered under the Plan.
- (b) Plan Sponsor means the [\_\_\_\_\_] Presbyterian Church (U.S.A.).

## 8.04 Disclosures to Plan Sponsor for Plan Administration

The Plan may disclose Protected Health Information to the Plan Sponsor for purposes of administering the Plan. These purposes shall include the following:

- (a) Confirmation of and other administrative actions and decisions relating to enrollment, contributions to the Plan, premium payments, and the payment of administrative fees;
- (b) Utilization management, including precertification, concurrent and retrospective review, case management, and qualification for a program for high-risk or other specified procedures;
- (c) Predetermination of benefits;
- (d) Processing, adjudication, notification, and payment of claims and claim appeals;
- (e) Claims status and medical necessity reviews;
- (f) Response to individual complaints, grievances, or inquiries relating to claims or other Plan administrative matters;
- (g) Coordination of benefits, subrogation and other third party recoveries;
- (h) Stop loss claims and coverage;
- (i) Audits and investigations of claims, systems, network operations, and other matters relating to Plan administration and the review of reports relevant to Plan administration;
- (j) Operation of wellness, prevention, and disease management programs in connection with the Plan;
- (k) Placement of information on a web site or in other accessible form or media;

- (l) Reporting, disclosure and other obligations that are required by law or specifically authorized by HIPAA and other applicable law, and contemplated by the notice of privacy practices distributed by the Plan in accordance with section 45 C.F.R. 164.520, including: (i) use and disclosure to the Secretary of Health and Human Services when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule; (ii) use and disclosure in response to a valid exercise by a Covered Individual of that individual's rights to gain access to or amend Protected Health Information in his or her own Designated Record Set or obtain information necessary to provide an accounting of certain disclosures of his or her own Protected Health Information; and (iii) appropriate use and disclosure in connection with certain law enforcement or public health activities or judicial or administrative proceedings;
- (m) The transfer of assets or liabilities under the Plan or due diligence in connection with such a transfer.
- (n) Determinations with respect to an individual's loss or reduction of coverage or benefits under the Plan; and
- (o) Investigation of fraud, abuse, or unlawful acts related to the Plan.

The Plan may disclose Protected Health Information to the Plan Sponsor for other purposes relating to Plan administration, including activities that are regarded as Payment or Health Care Operations. However, all disclosures under this Section 8.04, including those specifically identified, must pertain to the administration of the Plan. If Protected Health Information has been disclosed for permissible purposes under this Article VIII, the Plan Sponsor may de-identify and remove certain individually identifiable information from such Protected Health Information for other purposes.

#### 8.05 Requirements of Plan Sponsor

With respect to Protected Health Information that the Plan Sponsor receives with respect to the Plan pursuant to Section 8.04, the Plan Sponsor shall:

- (a) Not use or disclose the Protected Health Information other than for Plan administration, or as otherwise required by law and, specifically not use or disclose the Protected Health Information for employment-related actions or decisions or in connection with any employee benefit plan or benefit provided by the Plan Sponsor other than the Plan or a health benefit provided under the Plan.
- (b) Ensure that any agent (including a subcontractor) to whom the Plan Sponsor provides the Protected Health Information agrees to the same restrictions and conditions with respect to that information as apply to the Plan Sponsor under this Article.
- (c) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures set forth in Section 8.04 of this Article and of which the Plan Sponsor becomes aware.

- (d) Report to the Plan any Security Incident of which the Plan Sponsor becomes aware.
- (e) Make the Protected Health Information of a Covered Individual available to that Covered Individual, upon the individual's written request, as and to the extent required by the Privacy Rule.
- (f) Incorporate amendments of information included in the Designated Record Set of a Covered Individual upon the individual's request as and to the extent required by the Privacy Rule.
- (g) Make available to a Covered Individual upon the individual's written request, the information necessary to provide an accounting of the disclosures of Protected Health Information as and to the extent required by the Privacy Rule;
- (h) Make the Plan Sponsor's internal practices, books and records relating to the use and disclosure of the Protected Health Information available to the Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;
- (i) If feasible, return or destroy all of the Protected Health Information that the Plan Sponsor maintains and retain no copies thereof; or, if such return or destruction is not feasible, limit further uses and disclosures of Protected Health Information to the purposes that make the destruction or return infeasible.
- (j) With respect to Electronic Protected Health Information, implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, maintains or transmits on behalf of the Plan.
- (k) Require that members of its Workforce shall have access to the Protected Health Information only in connection with performance of the administrative functions that the Plan Sponsor performs for the Plan. The following individuals or classes of individuals shall have access to such Protected Health Information:
  - (i) Benefits;
  - (ii) Member Services;
  - (iii) Information Systems;
  - (iv) Mailroom/Fax Delivery;
  - (v) Finance/Treasury;
  - (vi) Accounting; and

(vii) Audit

In addition, support staff assisting the above members of the Plan Sponsor's workforce, including clerical, mailroom, and fax delivery staff may have access to the Protected Health Information. The limitations of this Section 8.05(k) shall be supported by reasonable and appropriate security measures.

The [\_\_\_\_\_] may designate other individuals or classes of individuals who may be furnished with access to the Protected Health Information with respect to administrative functions that the Plan Sponsor performs for the Plan. The Plan shall be deemed amended to the extent such a designation is made.

- (1) Ensure that, if the Plan Sponsor becomes aware of any issues relating to non-compliance with the requirements of this Article, the Plan Sponsor shall undertake an investigation to determine the extent, if any, of such non-compliance; the individuals, policies, or practices responsible for the non-compliance; and, to the extent feasible, appropriate means for curing or mitigating the effects of non-compliance and preventing such non-compliance in the future. Any individual who is determined by the Plan Sponsor to be responsible for such non-compliance, shall be subject to disciplinary action, as determined by the Plan Sponsor, in its sole discretion. Such disciplinary action may include one or more of the following to the extent not inconsistent with other applicable disciplinary policies established by the Plan Sponsor: written or oral warning or reprimand, required additional training and education with respect to the use or disclosure of or requests for Protected Health Information, limitations on or revocation of access to Protected Health Information, diminution of duties, suspension, probation, disqualification for bonus or other pay or promotion, demotion in pay or status, referral for criminal prosecution or a requirement to reimburse the Plan or Plan Sponsor for damages, removal from position or discharge.

8.06 Access to Protected Health Information

The Plan shall disclose Protected Health Information to the Plan Sponsor and to the individuals described in Section 8.05(k) pursuant to disclosures described in Section 8.04 only if the Plan Sponsor has certified to such entity that the Plan has been amended to incorporate the provisions of Section 8.05 of this Article as it relates to the Privacy Rule and that the Plan Sponsor agrees with the restrictions and other rules set forth in such provisions.

8.07 Personal Representative

The Plan shall recognize an individual who is the Personal Representative of a Covered Individual as if the individual were the Covered Individual himself or herself, provided that the individual satisfies the procedures established by the Plan Sponsor for verifying a Personal Representative's status and authority.

#### 8.08 Other Disclosures to Plan Sponsor

Nothing in this Article shall prohibit or, in any way, limit the Plan from disclosing Protected Health Information to the Plan Sponsor where HIPAA permits such disclosure in the absence of the provisions set forth in Sections 8.04 and 8.05, including, to the extent permitted by HIPAA the disclosure of Protected Health Information:

- (a) Pursuant to and in accordance with a valid individual authorization under the Privacy Rule;
- (b) That is Summary Health Information upon the Plan Sponsor's request for purposes of modifying, amending or terminating the Plan or obtaining bids from a Health Insurance Issuer;
- (c) Contained in a Limited Data Set pursuant to and in accordance with a valid Data Use Agreement for purposes of research, public health activities and health care operations;
- (d) Pursuant to a Business Associates Contract;
- (e) Regarding enrollment in or disenrollment from the Plan or any benefit option under the Plan;
- (f) For purposes of Treatment; or
- (g) To conduct research or to avert a serious and imminent threat to the health or safety of an individual or group of individuals to satisfy a legal requirement, or to otherwise fulfill a purpose specifically authorized by HIPAA and contemplated by the Plan's notice of privacy practices.

#### 8.09 Effect on Health Insurance Issuers

Health Insurance Issuers providing benefits under the Plan may disclose information to the Plan Sponsor under the same terms and conditions as apply to the Plan under other Sections of this Article. With respect to Protected Health Information received from a Health Insurance Issuer, the Plan Sponsor shall have the same obligations to that Health Insurance Issuer that it has to the Plan with respect to Protected Health Information received from the Plan.

#### 8.10 Organized Health Care Arrangement

Notwithstanding anything in this Article to the contrary, to the extent HIPAA allows, the Plan may disclose Protected Health Information to another plan that belongs to the same Organized Health Care Arrangement as the Plan and that information shall be regarded as Protected Health Information with respect to such other plan for purposes of the Plan Sponsor's use and disclosure thereof.

8.11 HIPAA Designees

For purposes of complying with HIPAA, the privacy official shall be [\_\_\_\_\_] and the security official shall be [\_\_\_\_\_].

8.12 Action by the Plan Sponsor

The Plan Sponsor may act as prescribed in this Article or may delegate, in writing and in its sole discretion, any and all of its functions under this Article to a committee, the Plan's privacy or security official, or other officer(s) or employee(s) of the Plan Sponsor. The Plan Sponsor or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions hereunder.

ARTICLE IX

MISCELLANEOUS

9.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any of its employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of such an employee to perform fully his duties in a satisfactory and businesslike manner, nor shall it affect any Employer's right to discipline, discharge, or take any other action with respect to such an employee.

9.02 Legal Compliance

The Employer may prospectively limit, reallocate or deny any benefit for a Participant or any group of Participants to the extent necessary to avoid discrimination under or otherwise comply with any pertinent provision of the Code or other applicable law.

9.03 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and, to the extent not superseded, with the laws of the State of [\_\_\_\_\_]. Benefits provided under this Plan are intended to be exempt from taxation under section 105 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable to church plans for purposes of retaining such tax exemption.

9.04 No Guarantee of Tax Consequences

Notwithstanding any provision of this Plan to the contrary, the Employer and the Plan Administrator make no commitment or guaranty that any amounts paid to or for the benefit or coverage of a Participant under this Plan shall be excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other particular federal, state or local tax treatment shall apply or become available to any

Participant as a result of the operation of this Plan. By accepting a benefit under this Plan, a Participant agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest or penalties that may be imposed in connection with the tax.

9.05 Family Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Treasury Regulation section 1.125-3.

9.06 Uniform Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

9.07 Invalid Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

[\_\_\_\_\_  
PRESBYTERIAN CHURCH (U.S.A.)]

By: \_\_\_\_\_  
Name:  
Title: