SUMMARY

for

ATRIUM HEALTH
On-Site Care and Employee Assistance Program

Amended and Restated January 1, 2018; Amended October 1, 2018; Amended January 1, 2019

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NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY

Atrium Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Atrium Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Atrium Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages
- If you need these services, call (800) 821-1535

If you believe that Atrium Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Steven B. Martin
Vice President
Atrium Health
720 East Morehead Street
Charlotte, NC 28204
(704) 355-3777 (phone)
(704) 355-7449 (fax)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Steven B. Martin, Vice President, is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal or by mail or phone at:

US Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1 (800) 368-1019, 1 (800) 537-7697 (TDD)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (800) 204-2085.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800)204-2085.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 204-2085.

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한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 204-2085 번으로 전화해 주십시오.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 204-2085.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 2085-204 (800)

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 204-2085.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 204-2085.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 204-2085.

ગુજરાતી (Gujarati): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (800) 204-2085.

ប្រយ័ត្ន៖ (Mon-Khmer Cambodian): បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 204-2085 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 204-2085.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 204-2085 पर कॉल करें।

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ (800) 204-2085.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 204-2085 まで、お電話にてご連絡ください。

INTRODUCTION

This Summary describes the circumstances when this Option pays for certain limited health care services under the On-Site Care Option. All decisions regarding health care are up to the Teammate and his or her Physician. There may be circumstances when a Teammate and his or her Physician determine that health care which is not covered by this Option is appropriate.

Changes in this Option may occur in any or all parts of this Option including copays, limitations, eligibility and the like.

The Employer fully intends to maintain this Option indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend this Option at any time and for any reason.

Purpose

- This document is a Summary of the *Atrium Health On-Site Care and Employee Assistance Program.*
- This Option is designed to protect Teammates against certain health expenses.
- This Option is not to be construed as a contract for or a guarantee of employment. Nothing in this Option shall be deemed to:
  - Affect the right of the Employer to discipline or discharge any Teammate at any time.
  - Affect the right of any Teammate to terminate his or her employment at any time.
  - Give the Employer the right to require any Teammate to remain in its employ.
  - Give the Teammate the right to be retained in the employ of the Employer.

Exclusive Benefit

- This Option is established and shall be maintained for the exclusive benefit of eligible Teammates.
- Coverage under this option will take effect for an eligible Teammate when the Teammate satisfies all of the eligibility requirements of the Employer.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- This Option is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change this Option.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after time when written proof of loss is required to be furnished to the Third Party Administrator.
- Should any part of this Summary for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Summary has been executed with the invalid portion thereof eliminated.

GENERAL INFORMATION

TYPE OF ADMINISTRATION: This Option is a self-funded group health Option and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and per-visit fees paid by Teammates.

OPTION NAME: Atrium Health On-Site Care and Employee Assistance Program

EMPLOYER GROUP NUMBER: 301

TAX ID NUMBER: 56-0529945

OPTION EFFECTIVE DATE: May 16, 2011
Amended and Restated January 1, 2012; Amended May 1, 2014; Amended and Restated January 1, 2015; Amended and Restated January 1, 2016; Amended and Restated January 1, 2018; Amended and Restated October 1, 2018; Amended January 1, 2019

EMPLOYER INFORMATION:
The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health
PO Box 32861
Charlotte, North Carolina 28232-2861
704-631-0263

AGENT FOR SERVICE OF LEGAL PROCESS
The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health
PO Box 32861
Charlotte, North Carolina 28232-2861

THIRD PARTY ADMINISTRATOR
MedCost Benefit Services, LLC
165 Kimel Park Drive
Winston-Salem, North Carolina 27103
336-774-4400

CLAIMS ADMINISTRATOR
MedCost Benefit Services*
PO Box 25987
Winston-Salem, North Carolina 27114-5987
800- 204-2085

**In compliance with California law, MedCost Benefit Services operates in the state of California as "MedCost Benefit Services d/b/a MBS Third Party Administrators."*

GENERAL PROVISIONS

Teammates should contact Atrium Health to obtain additional information, free of charge, about this Option's coverage or any aspect of benefits or requirements. Atrium Health is responsible for determining and providing the benefits of this Option, not the Third Party Administrator.

ELIGIBILITY

Eligibility Requirements for Teammate Coverage
All Teammates of the Employer are eligible beginning on their first day of employment. Their Dependents (ages 3 and over) enrolled in the LiveWELL Health Plan can access services through On-Site.

TERMINATION OF COVERAGE

When Teammate Coverage Terminates
Teammate coverage will terminate on the day the covered Teammate terminates employment. (See the *Continuation Coverage Rights under COBRA*.) Dependent coverage terminates when Coverage terminates with the exception of the end of the month during which a covered Dependent's 26th birthday occurs.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled *Continuation Coverage Rights under COBRA*.

Non-FMLA Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff
A person may remain eligible for a limited time if work ceases due to disability, leave of absence or layoff (provided the Option does not terminate during this period). Refer to the *Atrium Health Policy and Procedural Manual* or contact Atrium Health Benefit Administration.

While continued, coverage will be that which was in force on the last day of employment.

Continuation during Family and Medical Leave (FMLA)
Regardless of the established leave policies mentioned above, if the Employer is subject to FMLA regulations, this Option shall at all times comply with the *Family and Medical Leave Act of 1993* as promulgated in regulations issued by the Department of Labor.

The following is a brief description of the main provisions of the *Family and Medical Leave Act of 1993*. It does not detail every provision of the Act. Teammates should contact the Benefits Department for additional information or a copy of the Employer's written policy regarding compliance with the *Family and Medical Leave Act.*

The Act provides that a covered Teammate may continue his or her coverage under the Plan for a maximum of 12 weeks during a qualified leave of absence, which includes any of the following:

- The birth of a child, or placement of a child for adoption or foster care;
- To care for a spouse, child, or parent with a serious health condition;
- As a medical leave when the Teammate is unable to work due to a serious medical condition; or
- Any qualifying exigency (i.e., emergency or necessity) arising out of the fact that the Teammate's Spouse, son, daughter or parent is a military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

Additionally, the Act provides that a covered Teammate may continue his or her coverage under the Plan for a maximum of 26 weeks in a single 12-month period during a leave of absence to care for a service member with a serious injury or illness incurred in the line of duty. The covered Teammate must be a Spouse, son, daughter, parent or next of kin of the injured or ill service member.

To be eligible, the covered Teammate must have been employed with the Employer for at least 12 months, must have worked at least 1250 hours during the 12 months preceding the leave, and must be employed at a worksite where 50 or more Teammates are employed within 75 miles of that worksite*. The 12 months an Teammate must have been employed do not have to be consecutive. Whether an Teammate has worked at least 1250 hours during the preceding 12 months must be determined as of the date the leave is to begin.

(Teammates who are exempt from the *Fair Labor Standards Acts'* minimum wage and overtime requirements, and who have been employed for at least 12 months are presumed to have met their 1250-hour eligibility.)

During an FMLA qualified leave of absence, the Teammate's benefits under this Option may continue as if he or she were actively at work. The Teammate must continue to pay any part of the cost he or she was required to pay before the leave began.

Note: The Employer makes the determination as to whether the Employer is subject to FMLA regulations, and whether or not the Teammate meets the eligibility requirements for leave under FMLA. Teammates should contact the Benefits Department with questions related to FMLA.

Medical Residents
Upon completion of residency and signature of continuation contract, coverage continues under this Option during hiatus for up to six (6) months, with coverage continuing under this Option upon return to work with the Employer. (Please see Human Resources for details should extenuating circumstances occur.)

Teammates on Military Leave (USERRA)
In any case in which a Teammate has coverage under this Option, and such Teammate is absent from such position of employment by reason of service in the uniformed services, the Teammate may elect to continue coverage under this Option as provided in this section. The maximum period of coverage of the Teammate under such an election shall be the lesser of:

- The 24 month period beginning on the date on which the Teammate's absence begins; or
- The day after the date on which the Teammate fails to apply for or return to a position of employment, as determined under the *Uniformed Services Employment and Re-Employment Rights Act (USERRA)*.

A Teammate who elects to continue this Option coverage under this section must pay the designated premium for continued coverage under the Plan. Except that, in the case of a Teammate who performs service in the uniformed services for less than 31 days, such Teammate will pay his or her normal contribution for the 31 days.

A Teammate who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under this Option upon re-employment, except for any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

BENEFITS DESCRIPTION

On-Site Clinics:

When you're at work and health symptoms arise, Atrium Health On-Site Care is available for convenient, reliable and cost- effective care. Our Nurse Practitioner treats illnesses with symptoms that are expected to last for a short duration with treatment including cold, cough, bronchitis and flu; ear, sinus, and upper respiratory infections; seasonal allergies; or minor injuries such as splinters, sprains or cuts, and occupational injuries/illnesses. Annual Wellness Visits may also be obtained for members of the LiveWELL Health Plan at On-Site Care locations. Please see the Questions and Answers section at the back of this booklet or visit the Benefits Department with questions or for more details.

A nurse practitioner, also commonly known as a mid-level provider, will provide care at each location. The nurse practitioner is supervised by a licensed physician in the State of North Carolina and, under the rules, can practice independently. The nurse practitioner can diagnose and treat injuries and illnesses and write certain levels of prescriptions if needed.

Atrium Health On-Site Care is available to all Teammates of Atrium Health. In addition, Dependents (age 3 and above) who are enrolled in the LiveWELL Health Plan may access care from the On-Site Care locations.
As part of the Atrium Health Total Rewards package, non-exempt Atrium Health Teammates receive up to one hour of paid-time to accommodate their appointment.

Fees for On-Site Care visits range from $40-$120 depending on the level of service until the annual Deductible is met, After the Deductible is met members enrolled in the LiveWELL Health Plan pay a fee of $10 that applies toward the Out-of-Pocket Maximum.

Employee Assistance Program (EAP):

Atrium Health offers an Employee Assistance Program (EAP) to all Teammates and their Dependents. Available through Atrium Health, this program is designed to help you with all types of issues – marital conflict, financial problems, job stress, emotional problems, alcohol and drug problems, legal issues and difficulties with children. There is no charge to you when you visit with an EAP counselor. The counselor will help clarify your concerns and offer treatment options. If further counseling is required, you will be referred to area treatment professionals whose services can often be billed to your health plan. Your decision to use EAP is voluntary and confidential. The counselors must follow strict legal guidelines regarding disclosure or program participation. For more information, call the EAP office of Atrium Health at (704) 355-5021 or (800) 384-1097.

Virtual Visit:

A Virtual Visit benefit is available to all Atrium Health Teammates. The Virtual Visit benefit provides a Teammate with the opportunity to communicate his or her health concerns and questions by speaking directly with a medical provider on-line at the mutual convenience of the Teammate and the provider. Note, for Teammates enrolled in the Plan, please refer to the Schedule of Benefits in the Summary Plan Description. For more information, call Atrium Health Virtual Visit at (855) 438- 0010.

SERVICES NOT PROVIDED

The following services are NOT PROVIDED under this Option:

Prescription refills - Maintenance prescription refills should be handled by your primary care provider. If you do not have a primary care provider you may call the Provider Referral Line at (704) 355-7500 or (800) 821-1535 to speak with an associate.

Routine laboratory services - Routine laboratory services should be obtained through your primary care provider.

Immunizations - Atrium Health On-Site Care will not offer immunization services. We recommend you use your primary care provider to obtain immunizations. *Note, if you enroll and are covered under the Atrium Health Medical Plan, immunizations are covered at 100 percent.*

Break area for migraine headaches - The clinic cannot be utilized as a break area. Atrium Health On-Site Care is designed to treat minor illnesses and occupational injuries and other non-emergent conditions. The clinic is set up to treat and release patients.

Please note: This Option does not provide any Coordination of Benefits with any plan of health care coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA contains provisions giving certain former Teammates, Spouses and Dependent children the right to temporary continuation of health coverage.

Beneficiary

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event. A Qualified Beneficiary may be a Teammate, the Teammate's Spouse and Dependent children, and in certain cases, a Retired Teammate, the Retired Teammate's Spouse and Dependent children. COBRA continuation coverage is provided subject to your eligibility for coverage. See also Rescission of Coverage.

Qualifying Events

"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for Teammates are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **Spouses** are:

- Termination of the covered Teammate's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered Teammate
- Covered Teammate becoming entitled to Medicare
- Divorce or legal separation of the covered Teammate
- Death of the covered Teammate

The types of qualifying events for **Dependent children** are the same as for the Spouse with one addition:

- Loss of "Dependent child" status under the plan rules

Periods of Coverage

Qualifying Events	Beneficiary	Coverage
-Termination -Reduced hours	-Teammate -Spouse -Dependent child	-18 months
-Teammate entitled to Medicare -Divorce or legal separation -Death of covered Teammate	-Spouse -Dependent child	-36 months
-Loss of "dependent child" status	-Dependent child	-36 months

Your Rights; Notices and Elections Procedures

COBRA outlines procedures for Teammates and family members to elect continuation coverage and for Employers and plans to notify beneficiaries. The Qualifying Events contained in the law create rights and obligations for Employers, plan administrators and qualified beneficiaries.

Qualified Beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices
An initial general notice must be furnished to Covered Teammates, their Spouses and newly hired Teammates informing them of their rights under COBRA and describing provisions of the law.

Specific Notices
Specific notice requirements are triggered for Employers, Qualified Beneficiaries and plan administrators when a Qualifying Event occurs. Employers must notify plan administrators within 30 days after a Teammate's death, termination, reduced hours of employment, or entitlement to Medicare.

A Qualified Beneficiary must notify the Plan Administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a Qualifying Event, must automatically provide a notice to Teammates and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a Qualifying Event has occurred.

Election
The election period is the time frame during which each Qualified Beneficiary may choose whether to continue health care coverage under an Employer's group health plan. Qualified Beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the Qualified Beneficiary.

A covered Teammate or the covered Teammate's Spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary. Each Qualified Beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a Qualified Beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Covered Benefits
Qualified Beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under plans maintained by the Employer. Assuming a Qualified Beneficiary had been covered by three separate health plans of his former Employer on the day preceding the Qualifying Event, that individual has the right to elect to continue coverage in any of the three health plans.
Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active Teammates may apply to Qualified Beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

Duration of Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for Qualifying Events due to employment termination or

reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a Qualifying Event and can end when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.
- The Employer ceases to maintain any group health plan.
- Coverage is obtained with another Employer group health plan
- A beneficiary is entitled to Medicare benefits.

Special rules for disabled individuals may extend the maximum periods of coverage. If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the Qualified Beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to Qualified Beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Paying for COBRA Coverage

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 % of the cost to the plan for similarly situated individuals who have not incurred a Qualifying Event. Premiums reflect the total cost of group health coverage, including both the portion paid by Teammates and any portion paid by the Employer before the Qualifying Event, plus 2% for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The Plan must allow you to elect to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the Pan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1st and coverage for January could not be canceled if payment is made by January 31st.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the Pan. The Plan, however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to Deductibles, catastrophic and other benefit limits.

Claims Procedures

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whoever is designated to operate the health plan (Employer, Plan Administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the Plan:

- provides for a special hearing, or

- the decision must be made by a group that meets only on a periodic basis.

Contact the Plan Administrator for more information on filing a claim for benefits. Complete plan rules are available from Employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Coordination with Other Benefits

The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an Employer to maintain coverage under any "group health plan" for a Teammate on FMLA leave under the same conditions coverage would have been provided if the Teammate had continued working. Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a Qualifying Event under COBRA. A COBRA Qualifying Event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as when a Teammate notifies an Employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Role of the Federal Government

Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements. If you need further information on your election or notification rights with a private sector plan, write to the nearest office of the Employee Benefits Security Administration or the U.S. Department of Labor, Employee Benefits Security Administration, Division of Technical Assistance and Inquiries, 200 Constitution Ave., N.W. (Room N-5619) Washington, D.C. 20210.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." Information about COBRA provisions concerning public sector employees is available from the:

U.S. Public Health Service Office of the Assistant Secretary for Health Grants Policy Branch (COBRA) 5600 Fishers Lane (Room 17A-45) Rockville, Maryland 20857

Conclusion

For most Americans, rising medical costs have transformed health benefits from a privilege to a household necessity. COBRA creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your health benefits plan.

Be sure to periodically contact the Plan Administrator to find out about any changes in the type or level of benefits offered by the plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A detailed description of a Teammate's Privacy Rights is found in the ***Joint Notice of Privacy Practices –Atrium Health – Group Health Plan and Medical Reimbursement Plan***, which has been distributed to each Teammate covered under this Option.

This Option and those administering it will use and disclose health information only as allowed by federal law. If a Teammate has a complaint, questions, concerns, or requires a copy of the Privacy Notice, please contact Atrium Health Benefits Administration.

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Teammates from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Teammates are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

- **General**. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

- **Permitted Uses and Disclosures**. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf in the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- **AuthorizedTeammates**. The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Teammates and other persons under the control of the Employer.

    - **Updates Required**. The Employer shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

    - **Use and Disclosure Restricted**. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

    - **Resolution of Issues of Noncompliance**. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

        - Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
        - Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
        - Mitigating any harm caused by the breach, to the extent practicable; and
        - Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

- **Certification of Employer**. The Employer must provide certification to the Plan that it agrees to:
  - Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents as required by law;
  - Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by the Amendment, or required by law;
  - Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  - Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
  - Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
  - If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
  - Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

FEDERALLY MANDATED AMENDMENT TO PLAN DOCUMENT REGARDING HIPAA SECURITY STANDARDS

n accordance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information, this Plan Document of the Atrium Health LiveWELL Health Plan is hereby amended as follows:

Definitions

A. Electronic Protected Health Information – the term "Electronic Protected Health Information" has the meaning as set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

B. Plan – the term "Plan" means this Group Health Plan.

C. Plan Document – the term "Plan Document" means the group health plan's governing document and instruments (i.e. the document under which the group health plan was established and is maintained).

D. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

E. Plan Sponsor shall ensure that any Business Associate, or agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and

F. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.