

COMMONWEALTH OF VIRGINIA

Flexible Benefits Plan

Medical Reimbursement Account III

Plan Document

ARTICLE I

Name, Purpose, and Effective Date

- 1.01 **Name and Purpose of Plan.** The Department of Human Resource Management hereby restates the Commonwealth of Virginia Medical Reimbursement Account III (hereinafter referred to as the "Medical Reimbursement Account III").

The purpose of the Medical Reimbursement Account III is to reimburse Employees for certain medical expenses not reimbursed by any other health plan. The Medical Reimbursement Account III is intended to comply with the requirements of Sections 105, 106, and 125 of the Internal Revenue Code of 1986, as amended (the "Code").

The Medical Reimbursement Account III shall be interpreted where possible to comply with the terms of the Code and all regulations and rulings issued under the Code and amendments thereto.

This document restates the plan to incorporate all amendments and changes in regulations subsequent to its adoption January 1, 1996.

- 1.02 **Effective Date.** The effective date of the Plan is January 1, 2004. Revised February 1, 2011

ARTICLE II

Definitions

The following words and phrases shall have the following meanings unless a different meaning is plainly required by the context.

- 2.01 Benefits means the amounts paid to Participants under the Medical Reimbursement Account III as reimbursements for eligible Medical Expenses paid or incurred by a Participant or his Dependent.
- 2.02 Code means the Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings pertaining to such section and shall also be deemed a reference to comparable provisions of future laws.
- 2.03 Coverage Period normally means the Plan Year. For any Employee who becomes a Participant after the start of a Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Participant's participation and extending through the remainder of the Plan Year. For any Employee who terminates membership in the Plan in accordance with Section 3.03, such participation shall extend through the date of termination of participation as specified in Section 3.03.
- 2.04 Dependent means a Participant's Spouse, child (ren) or other Dependent of the Participant as defined in Code §152.
- 2.05 Effective Date means January 1, 2004, or such later date, as of which an Employer shall adopt the Medical Reimbursement Account III for its Employees.
- 2.06 Election Form means the form on, or Employee Self-Service system process in which the Participant specifies his election for the Plan Year or Period of Coverage.
- 2.07 Election Period means a period when a participant can make an election for the Plan prior to the beginning of the next Coverage Period (except for any Employee who first becomes eligible to be a Participant during a Coverage Period, in which case Section 5.04 shall apply).
- 2.08 Elective Employer Contribution means contributions made under the Plan pursuant to the salary reduction agreement between Employees and the Employer.
- 2.09 Employee means an employee as defined in Section 2.10 of the Commonwealth of Virginia Flexible Benefits Plan.
- 2.10 Employer means the Commonwealth of Virginia.
- 2.11 Extended Coverage Plans are those health insurance plans in which certain individuals are allowed, at their option to continue their participation under specific conditions.
- 2.12 Family Medical Leave – means any leave, paid or unpaid, that has been approved under the Family Medical Leave Act (FMLA) of 1993, as amended.
- 2.13 Highly Compensated Employee means an Employee described in Internal Revenue Code Section 414(q) and regulations thereunder. Key Employee means an Employee described in Internal Revenue Code Section 416(i)(1).

- 2.14 Medical Reimbursement Account III means the bookkeeping account established for each Participant to reflect the health care account transactions of the Medical Reimbursement Account III Plan in accordance with Article IV.
- 2.15 Medical Expense means expenses for medical care as defined in Code Section 213d.
- 2.16 Participant means any Employee who becomes a Participant pursuant to Article II.
- 2.17 Plan means the Commonwealth of Virginia Medical Reimbursement Account III and all authorized amendments.
- 2.18 Plan Administrator means the Department of Human Resource Management or its successor or successors which shall have the authority to administer the Medical Reimbursement Account III as provided in Article VI.
- 2.19 Plan Year means the period beginning January 1, and ending on June 30, 2004 and each twelve (12) month period thereafter commencing on July 1, and ending on June 30.
- 2.20 Qualifying Midyear Event – any event described in schedule A, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Employer or designee, in its discretion as Plan Administrator and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan
- 2.21 Spouse means the legally married husband or wife of a Participant. The marriage must be recognized as legal in the Commonwealth of Virginia.

ARTICLE III

Participation

- 3.01 Eligibility Each Employee who is eligible to participate under the terms of the Commonwealth of Virginia Health Benefits Program shall be eligible to participate in this plan. Any new Employee may elect to participate effective as of the first day of the month following his date of hire. Employees hired on the first of the month may participate in that month.
- 3.02 Enrollment Each Participant in this Medical Reimbursement Account III shall, during the applicable Election Period, complete a form or enrollment process through the Employee Self-Service System provided by the Plan Administrator evidencing the Participant's election. Such election shall be irrevocable until the end of the applicable Coverage Period unless the Participant is entitled to change his election pursuant to Section 5.05 hereof.
- A Participant shall be required to execute a new form or enrollment through the Employee Self-Service system process during the Election Period preceding each Coverage Period during which he wishes to participate in this Medical Reimbursement Account III.
- 3.03 Enrollment Periods:
- (a.) Annual Elections Each Participant shall have a Regular Election Period during which to make elections for the next Plan Year. The Regular Election Period for such Plan Year shall be determined by the Plan Administrator, but in no event shall be less than a 14 day period, and shall terminate no later than 15 days prior to the commencement of the next Plan Year. During the Election Period, each eligible Employee shall be given the opportunity to elect, on a form or Employee Self-Service system process provided by the Plan Administrator, the benefit as set forth in Section 5.01.
 - (b.) Elections by Newly Eligible Employees A newly eligible Employee's initial Election Period shall begin on the first day the Employee has met the requirements for participation herein and shall terminate 30 days thereafter. If the newly eligible Employee does not elect to participate during his initial Election Period, he may make an election at any subsequent Election Period.
 - (c.) Change of Elections A participant will not be permitted to change any elections made pursuant to the Medical Reimbursement Account III for a Plan Year after the deadline established by the Plan Administrator for the timely filing of such elections, except as provided in the next sentence. A Participant may change his benefit election, in accordance with rules promulgated by the Plan Administrator, for the remainder of such Plan Year solely to accommodate a qualifying mid-year event as set forth in Exhibit A of this plan. A participant who incurs a qualifying mid-year event shall have a special Enrollment period which shall begin on the date of his or her qualifying event and shall terminate 60 days thereafter or such other reasonable period of time as may be determined by the Plan Administrator
- 3.04 Termination of Participation A Participant shall continue to participate in this Medical Reimbursement Account III until the earliest of the following dates: (a) the end of the month in which the Participant terminates employment by death, disability, retirement or other separation from service, unless the Employee elects to continue participation under the provisions of the Commonwealth's Extended Coverage plan; (b) the end of the month in which the Participant ceases to work for the Employer as an eligible Employee, unless the Employee elects to continue participation under the provisions of the Commonwealth's Extended Coverage Plan, (c) the end of the month in which the Participant elects to terminate participation in the plan because of and consistent with a qualifying mid-year change, or (d) the

Participant fails to make an election during an Election Period, in which case his participation will cease at the end of the Coverage Period for which a prior election was made.

In the event that an Employee whose participation terminates in accordance with subsection 3.03 (c) and later experiences a qualifying mid-plan year event, such Employee shall be allowed to make a new election for the remaining portion of the Plan Year. The Participant's combined elections cannot exceed the annual plan year maximum as set forth in Section 5.02

- 3.05 Reinstatement of Former Participants. A former Participant who is rehired within 30 days or less of a termination of employment will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment, such individual shall be allowed to make a new election for the remaining portion of the Plan Year under the same provisions as a new hire for the Commonwealth. The Participant's combined elections cannot exceed the annual plan year maximum as set forth in Section 5.02.
- 3.06 Special Rules for Family Medical Leave. A Participant taking Family Medical Leave may revoke an existing election; and upon return from Family Medical Leave, may make such other election for the remaining election period as may be provided for under the Family Medical Leave. If the Family Medical Leave is paid, pre-tax contributions may continue to be made under the Plan as elected under Article III, Participation 3.02. However, an Employee shall be required to resume participation following a Family Medical Leave if the Employer requires Employees who return from non-family medical leaves to resume participation in the Plan.

If the Employee drops coverage under the Medical Reimbursement Account III during a period of Family Medical Leave, claims incurred during this period shall be ineligible for reimbursement. When the Employee returns from Family Medical Leave, the Employee may (a) resume coverage at a reduced level with the resumption of the prior contribution amount for each payroll, or (b) resume coverage at the original level and make up the unpaid contributions.

ARTICLE IV

Funding

4.01 Contributions The contributions required for an entitlement to Benefits under this Medical Reimbursement Account III shall be made pursuant to the terms of the Commonwealth of Virginia Flexible Benefits Plan of which this Medical Reimbursement Account III shall be deemed to be a Component Plan.

4.02 Medical Reimbursement Account III The Plan Administrator shall maintain a separate Medical Reimbursement Account III for each Participant. Contributions shall be credited to the Participant's account and all payments of benefit amounts under this Plan shall be debited against the account.

Any balance remaining in the account as of the last day of the third month following the prior Plan Year which is not used to provide benefits incurred during the Coverage Period shall be forfeited by the Participant and at the direction of the Plan Administrator shall be:

- (a) used by the Employer to defray losses, if any;
- (b) used by the Employer to pay administrative costs; or
- (c) distributed equally to Participants on a per capita basis.

4.03 Nature of Participant's Interest The use of Participant accounts pursuant to this Plan is intended as an accounting mechanism to measure the maximum benefit available to each Participant for each Plan Year and is not intended to create or imply any ownership or other legal or equitable interest by the Participant in the Participant account. Notwithstanding anything to the contrary in any Plan document including, without limitation, the Virginia Flexible Benefits Plan and any salary reduction agreement or other agreement with any participant in connection with the Plan, upon reduction of each Participant's covered compensation pursuant to the Plan, (a) the Participant shall have no further right to or interest in the pay thus withheld; and (b) any right or interest of the Participant is limited to the right to receive those Plan benefits and distributions which in fact become payable to, or for the benefit of, the Participant under the terms and conditions of the Plan.

ARTICLE V

Benefits

5.01 Benefits Every participant in the Plan shall be eligible to receive Benefits under the Medical Reimbursement Account III for all Medical Expense incurred by such Participant or his Dependents subject to the limitations of this article.

A Participant shall be entitled to Benefits under this Plan only for eligible Medical Expense (a) incurred after he became a Participant in this Plan, (b) incurred during the applicable Coverage Period, and (c) supported by the submission, on or before the last day of the third month following the applicable Plan Year, of the written statements required by this section.

This account shall reimburse, at convenient intervals, each eligible Participant for all medical and dental expenses, as defined in Code Section 213, up to the maximum amount of such account elected at the time the medical expense was incurred. Such expense reimbursement must be attributable to the Participant, paid for himself, or for his Spouse, or his Dependents in excess of any payments or other reimbursements under any health plan which may be sponsored by any employer, governmental agency or carried personally by said eligible Participant and covering himself and/or his Dependents.

In order to be reimbursed under this account, a Participant shall provide a written statement from an independent third party (inclusive of a bill or invoice) stating that the Medical Expense has been incurred and the amount of such expense. Further, the Participant shall provide a written statement that the Medical Expense is a covered Medical Expense, has not been reimbursed and is not reimbursable under any other health plan, and that expenses claimed were incurred by eligible persons.

Benefits provided hereunder shall be used to pay claims directly to the Participant. The general classes of covered expenses under the account will be:

- Nursing care,
- Hospital bills,
- Doctors' and dentists' bills,
- Psychiatric care,
- Legend drugs, prescriptions, and certain classes of over-the-counter drugs/supplies and
- Medical-related transportation.

Included in the foregoing, but not by way of limitation, will be all medical and dental expenses, including hospital expenses, both room and board and special hospital services; surgical expenses; diagnostic x-rays; prenatal and maternity expenses; infant care in hospital; services of physicians, surgeons and specialists, in or out of hospital; rental of iron lung or other equipment for therapeutic appliances; diagnostic laboratory procedures; legend drugs and medicine requiring prescriptions, and certain over-the-counter drugs as permitted under Code §213(d); oxygen; anesthesia; blood and plasma; x-ray and radium treatments; local professional ambulance services; psychiatric treatment; dental care; surgery and appliances; eye glasses; hearing aids and examination thereof.

5.02 Amount of Benefits The maximum election to a Medical Reimbursement Account III shall be made in whole dollar increments, on a per pay period basis, not to exceed twenty-five hundred dollars (\$2500) for the plan year commencing January 1 and ending on June 30, 2004. Thereafter, the maximum election to a Medical Reimbursement Account shall be made in whole dollar increments, not to exceed five thousand

Medical Reimbursement Account III

dollars (\$5,000) per plan year) . The minimum election to the Medical Reimbursement Account III shall be ten dollars (\$10.00) per pay period.

Amounts contributed to the Participant's Medical Reimbursement Account III shall be subject to the following requirements:

- (a) no interest shall be credited to such accounts;
- (b) reimbursements shall be paid to the participant at least monthly following submission of eligible medical expenses;
- (c) funds may not be transferred between this and any other accounts;
- (d) a Participant may submit eligible expenses incurred during the Coverage Period until the last day of the third month following the Plan Year; and
- (e) any balance in the Participant's account as of the last day of the third month following the prior Plan Year which was not used to provide benefits incurred during the Coverage Period shall be forfeited by the Participant and retained by the Plan.

ARTICLE VI

Administration

- 6.01 Allocation of Responsibility The Employer and Plan Administrator shall have only those powers, duties, responsibilities and obligations as are specifically given or delegated to them under this Medical Reimbursement Account III.
- (a) The Employer shall have the sole responsibility for making the employer contributions under the Medical Reimbursement Account III as specified in Article IV.
 - (b) The Employer shall have sole authority to appoint and remove the Plan Administrator, and to amend or terminate this Medical Reimbursement Account III in whole or in part.
 - (c) In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with the duty and discretionary authority necessary to enable it to carry out properly such duties.
- 6.02 Administration The Medical Reimbursement Account III shall be administered by the Plan Administrator which, subject to and in accordance with any applicable laws may appoint or employ persons to assist in the administration of the Medical Reimbursement Account III or any other agents it deems advisable, including legal counsel, actuaries, auditors, bookkeepers and recordkeepers to serve at the Plan Administrator's direction. All usual and reasonable expenses of the Medical Reimbursement Account III and the employer may be paid by the Participants. An administrative fee to be determined by the Plan Administrator may be charged to each Participant. The administrative fee shall be considered a Coverage Expense as defined in Section 2.03 of the Commonwealth of Virginia Flexible Benefits Plan.
- In accordance with Sections 105(h) and 125 of the Internal Revenue Code, the Medical Reimbursement Account III is intended not to discriminate in favor of "Highly Compensated Employees", as defined in the Internal Revenue Code. If, in the operation of the Medical Reimbursement Account III, it is discovered that the Plan discriminates in favor of such Highly Compensated Employees (or in the opinion of the Plan Administrator, is in danger of discrimination), then notwithstanding any other provision contained herein, the Plan Administrator shall reduce or adjust such contributions and/or benefits under the Medical Reimbursement Account III as shall be necessary to assure that, in the judgement of the Plan Administrator, the Medical Reimbursement Account III thereafter will not discriminate. Such reductions or adjustments in contributions and/or benefits will be made in a uniform and nondiscriminatory manner. All rules, procedures, and decisions of the Plan Administrator shall be adopted, made and/or applied in such fashion that they do not discriminate in favor of Highly Compensated Employees.
- 6.03 Rules and Decisions The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable or appropriate for the administration of this Plan. All rules, procedures and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, a Dependent, the duly authorized representative of a Participant or Dependent, or the legal counsel of the Plan Administrator.
- 6.04 Forms and Requests for Information The Plan Administrator may require a Participant to complete and file such forms as are provided for herein and all other forms prescribed by the Plan Administrator. The Plan Administrator may rely upon all such information, including the Participant's current mailing address.
- 6.05 Responsibility for Plan The complete authority to control and manage the operation and administration of the Medical Reimbursement Account III shall be placed in the Plan Administrator, who shall be solely responsible for the operation of the Medical Reimbursement Account III in accordance with its terms.

- 6.06 Examination of Records The Plan Administrator shall make available to each Participant such records as pertain to the Participant for examination at reasonable times during normal business hours.
- 6.07 Account Statements The Medical Reimbursement Account III shall provide for participants a written statement showing the amounts paid or expenses incurred in providing medical care reimbursement to such Participant during the Plan Year.
- 6.08 Appeals: Claims for benefits under this Plan are to be submitted to the Plan Administrator, or the designated appointee. Appeals of final benefit decisions made by the Plan Administrator, or the designated appointee, may be made to the Director of the Commonwealth of Virginia, Department of Human Resource Management, in writing within 60 days of the Plan Administrator's final denial. To appeal the Participant must submit the following:
- Full name;
 - Identification number;
 - The date of the service;
 - The type of services for which reimbursement was denied; and
 - The reason the participant believes the claim should be reimbursed.

The Participant is responsible for providing the Plan Administrator with all information necessary to review the denial of the claim, including any additional information the Participant wishes to have considered in the review, and will give the Participant the opportunity to explain, in person or by telephone, why they believe the expense should be reimbursed.

ARTICLE VII

Health Plan Continuation of Coverage

7.01 Continuation of Coverage The federal government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and amended the Public Health Service Act. These acts allow certain individuals the option of continuing their Medical Reimbursement Account III under specific conditions.

To the extent required by Federal law, a Participant, and the Participant's Spouse and Dependents, whose coverage terminates under the Medical Reimbursement Account III because of a COBRA qualifying event, shall be given the opportunity to continue coverage under this Plan on an after-tax basis.

Individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Reimbursement Account III balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event.). If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the Medical Reimbursement Account III will cease at the end of the year and cannot be continued for the next plan year.

Individuals will not be eligible for COBRA continuation coverage if they have a negative Medical Reimbursement Account III balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event.)

7.02 Notice by Employer. The Employer shall notify the Plan Administrator of one of the following qualifying events; which results in the termination of participation in the program.

- (a) the death of the covered Employee;
- (b) the termination of a covered Employee's employment (or ineligibility for coverage due to a reduction in hours);

The Employer shall give the notice not later than thirty-one days after the later of:

- (a) an individual's loss of coverage, or
- (b) one of the qualifying events shown above.

7.03 Notice by Plan Administrator. Within fourteen days after receiving notice by either an Employee or by the Employer of one of the qualifying events as shown above, the Plan Administrator shall notify the Employee or the Dependent of:

- (a) his right to elect to continue coverage, and
- (b) the time period in which the election must be made. Notice to an Employee's Spouse is considered to be notice to all children living with that Spouse.

7.04 Election Period. An individual will have sixty days to notify the Plan Administrator if he will continue coverage. This sixty days is from the later of:

- (a) the day the coverage is lost; or
- (b) the day on which the Plan Administrator sends notice of the right to elect continuation of coverage.

An individual who elects continuation of coverage will be allowed to elect continuation of coverage on behalf of all dependent children whose coverage would terminate due to the Employee's termination of group health coverage. Evidence of insurability cannot be a condition of continuation of coverage.

- 7.06 Continuation Coverage. Individuals whose coverage is continued shall receive identical coverage provided under the group plan for similarly situated active Employees and/or Dependents.

ARTICLE VIII

HIPAA Privacy - Disclosure of Protected Health Information

8.01 Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan-means the “State Health Benefits Program, including Medical, Prescription Drug, Dental, Vision and Health Care Flexible Reimbursement Account (FRA) benefits”

(b) Employer-means the “Commonwealth of Virginia.”

(c) Plan Administration Functions-means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(d) Health Information-means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(e) Individually Identifiable Health Information-means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(f) Summary Health Information-means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

8.02 The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

8.03 The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR § 164.504(f) and the provisions of this Section.

- 8.04 The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:
- (a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
 - (b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
 - (c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
 - (d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
 - (e) to make PHI available to individuals in accordance with HIPAA in 45 CFR §164.524;
 - (f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR § 164.526;
 - (g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR § 164.528;
 - (h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request;
 - (i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and
 - (j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR § 164.504(f), is established and maintained.

8.05 The Plan will disclose PHI only to the following employees or classes of employees:

- (a) Director, Department of Human Resource Management
- (b) Director of Finance, Department of Human Resource Management
- (c) Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

- 8.06 Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered “failure to comply with established written policy” (a Group II offense) and must be addressed under the Commonwealth of Virginia’s Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.
- 8.07 A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR § 164.520.

ARTICLE IX

Amendment or Termination of Plan

- 9.01 Amendment. The Employer by action of the Director of the Department of Human Resource Management shall have the right at any time to amend any or all of the provisions of the Medical Reimbursement Account III without the consent of any Employee or Participant. No amendment shall have the effect for any Participant of reducing any benefit election in effect at the time of such amendment, unless such amendment is made to comply with federal or local law, statute or regulations.
- 9.02 Termination. The Employer expects to continue the Medical Reimbursement Account III, but has the right by action of the Director of the Department of Human Resource Management, to terminate the Medical Reimbursement Account III, in whole or in part, at any time.

ARTICLE X

Miscellaneous

- 10.01 Plan Interpretation. This Plan document sets forth the provisions of this Plan. This Plan shall be read in its entirety and not severed except as provided in Section 9.04. The Plan Administrator shall have complete and absolute discretion regarding the interpretation of this plan document.
- 10.02 Limitation on Participant Rights. Nothing appearing in or done pursuant to the Medical Reimbursement Account III shall be held or construed:
- (a) to give any person any legal or equitable right against the Employer, except as expressly provided herein or provided by law; or
 - (b) to create a contract of employment with any Participant, to obligate the Employer to continue the service of any participant or to affect or modify his or her terms of employment in any way.
- 10.03 Governing Law. This Medical Reimbursement Account III is governed by the Internal Revenue Code and the regulations issued thereunder. In no event shall the Employer guarantee the favorable tax treatment sought by this Medical Reimbursement Account III. To the extent not preempted by federal law, the provisions of this Medical Reimbursement Account III shall be construed, enforced and administered according to the laws of the Commonwealth of Virginia.
- 10.04 Severability. If any provision of the Medical Reimbursement Account III is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Medical Reimbursement Account III, and the Medical Reimbursement Account III shall be construed and enforced as if such provision had not been included herein.
- 10.05 Captions. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Medical Reimbursement Account III nor in any way shall affect the Medical Reimbursement Account III or the construction of any provision thereof.
- 10.06 Construction. Whenever used in this Medical Reimbursement Account III, the masculine pronoun shall be deemed to include the masculine and feminine gender; a singular word shall be deemed to include the singular and plural and a plural word shall be deemed to include the plural and singular in all cases where the context requires; and, the term form with respect to enrollment processes shall refer to a paper document or Employee Self-Service transaction, whichever is applicable.

ARTICLE XI

Adoption of the Plan

IN WITNESS WHEREOF, the Commonwealth of Virginia has restated this plan document this _____ day of _____, 2011.

ATTEST: (SEAL)

COMMONWEALTH OF VIRGINIA

By _____

By _____

Director,
Office of Health Benefits Programs
Department of Human Resource Management

Schedule A - Qualifying Mid-Year Events

1. Change In Status

An Employee may change a benefit election when a valid change in status event occurs. However, the change must be made **on account of, and correspond with**, a change in status that affects the eligibility for coverage of the Employee, the spouse or the dependent of the Employee. Assuming that these general consistency requirements are satisfied, if the change in status event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage.

The following events constitute valid Changes in Status:

- a. Legal Marital Status: A change in legal marital status, including marriage, death of spouse or divorce
- b. Number of Dependents: A change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent.
- c. Change in Employment Status: Any change in employment status of the employee, the spouse or the dependent of the employee, including: termination or commencement of employment; a strike or lockout; commencement of or return from an unpaid leave of absence; change in work schedule, including an increase or decrease in the number of hours of employment; a switch between full-time and part-time status, or a change in worksite or any other similar change which results in a change in benefits eligibility
- d. Dependent Eligibility Requirement: An event that causes a dependent to satisfy or cease to satisfy the eligibility requirements for coverage as provided under the component plan under which the employee receives coverage, and
- e. Change in Residence: A change in the place of residence of the employee, spouse or dependent.

Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid Change in Status event. The IRS further clarifies that the Change in Status must result in the employee, spouse or dependent gaining or losing eligibility for coverage or for a particular coverage option such as managed care or indemnity.

2. Medical Child Support Order

If a judgment, decree or order requires that the Employee provide accident or health coverage for a dependent child, the Employee may change his election to provide coverage for the dependent child. If the Order requires that another individual (including the spouse or former spouse) cover the dependent child and provide coverage under that individual's plan, the Employee may change his election to revoke coverage for the dependent child.

3. **Medicare and Medicaid** If a Employee, spouse or dependent who is enrolled in a health or accident benefit under this plan becomes entitled to Medicare or Medicaid, (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Employee may prospectively reduce or cancel the coverage of the person becoming entitled to Medicare or Medicaid. Further if an Employee, spouse or dependent who had been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Employee may prospectively elect to commence or increase the coverage of the person losing coverage.