Jacksonville Police Officers and Fire Fighters
Health Insurance Trust Group Health Plan

Prescription Drug Plan Summary

Effective: July 1, 2020

Jacksonville Police Officers and Fire Fighters Health Insurance Trust Prescription Drug Plan

Jacksonville Police Officers and Fire Fighters Health Insurance Trust has established the Jacksonville Police Officers and Fire Fighters Health Insurance Trust Prescription Plan (the "Plan"), which is part of and incorporated by reference into the Jacksonville Police Officers and Fire Fighters Health Insurance Trust Group Health Plan. The Plan also includes medical coverage which is described in a Benefit Booklet issued by Florida Blue.

Claims administration for the Plan is provided by Express Scripts, Inc., a claims administrator contracted by the Plan to process prescription drug claims on its behalf.

This Plan Summary ("Summary") is issued by Jacksonville Police Officers and Fire Fighters Health Insurance Trust (the "Trust" or "JPOFFHIT") for delivery to each covered person. It describes the main features of the prescription drug coverage provided.

You are entitled to this coverage only during the period for which if you are eligible, become covered and remain covered. A clerical error or omission will not deprive you of your coverage, affect the amount of your coverage or affect or continue coverage which would not otherwise be in force. The Trust reserves the right to amend any and all provisions of the Plan without advance notice.

A. ABOUT THE PLAN

1. How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

2. Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network. You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.express-scripts.com.

B. GENERAL PROVISIONS

1. Effective Date

The benefits described in this Plan Summary became effective on July 1, 2020.

2. Eligibility

All employees who are enrolled in medical benefits under the Florida Blue health plan are eligible for benefits under this Plan. The Florida Blue medical benefit description describes the eligibility for medical benefits.

3. Enrollment and Termination

Once enrolled in the medical benefits, you and your dependents are automatically enrolled in the Prescription Plan. Coverage will terminate when medical coverage terminates and any changes made to your medical coverage will automatically change your coverage in the Prescription Plan, if applicable.

4. Continuation of Coverage under COBRA

You may be able to continue coverage under the Prescription Drug Plan under certain conditions if you choose to continue your Medical Plan Coverage. Medical plan coverage may be continued under certain circumstances under the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Please refer to your Medical Plan Booklet for information on when you may be able to continue your medical (and prescription drug) coverage when it would otherwise end.

5. Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Your current medical and prescription drug coverage may continue during your military service. If you choose not to continue your medical (and along with it, your prescription drug) coverage, while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave. In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

6. Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations (or 26 weeks for military caregiver leave) and

continue their elected medical and prescription coverage benefits during this time. The Trust is required to maintain group health insurance coverage for an employee on FMLA leave:

a) if the employee had such coverage before taking the leave, and
b) on the same terms as if the employee had continued to work.

Please refer to your medical plan booklet for information on when you may be able to continue your medical (and prescription drug) coverage when you go on an FMLA leave

C. BENEFITS AND DETAILS OF THE PRESCRIPTION DRUG PROGRAM

1. Claims Administrator

The Plan has contracted with Express Scripts to process prescription drug claims under the Plan and to provide additional services that are described in this Summary. Express Scripts uses a network of Participating Providers that are contracted to provide services at the maximum coverage level as shown on the Schedule for that benefit.

2. Identification of Network Participation

It is your responsibility when seeking benefits under this Plan to identify yourself as a covered person under the Plan and to assure that the prescription is filled at a network pharmacy. Always carry and present your Prescription Drug Identification Card.

You are required to pay any copay at the time you receive or request a prescription based on the location filled and the type of prescription as set forth in each Schedule of Benefits.

3. Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. There are no claim forms to complete when you use a network retail pharmacy. You can find a list of participating pharmacies at www.express-scripts.com.

4. If You Use an Out-of-Network Retail Pharmacy

If you use an out-of-network retail pharmacy, you pay the full cost of the covered prescription at the time of purchase, and then submit a claim form and receipt to Express Scripts. You will be reimbursed at the network retail level less your share of the cost and applicable deductible (if any). You also must pay any difference between the network negotiated rate and the pharmacy's actual charge.

5. Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail from the Express Scripts Pharmacy. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To order your prescription through the mail service pharmacy, visit the express-scripts.com website or call Member Services at 1-866-281-2409 to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and any applicable copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can also be conveniently refilled by phone or by using Pharmacy Manager's Web site www.express-scripts.com/rx.

6. Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. The copay for generic drugs is $0 per prescription for up to a 30-day supply. For generic drugs purchased through the mail service program, the copay is $0 per prescription for up to a 90-day supply.

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it. If you request brand-name when a generic drug is available, you will pay the difference between the generic and brand name drug and no limits will apply, if applicable. Your copay for formulary (brand-name) drugs at a network retail pharmacy is $40 per prescription for up to a 30-day supply. For formulary drugs purchased through the mail service program, the copay is $80 per prescription for up to a 90-day supply.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. Your copay for non-formulary drugs at a network retail pharmacy is $75 per prescription for up to a 30-day supply. For non-formulary drugs purchased through the mail service program, the copay is $150 per prescription for up to a 90-day supply.

7. Specialty Pharmacy Copay Assistance Program (SaveOnSP)

Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the covered person's out- of-pocket maximum. A list of these drugs can be obtained from **Accredo Specialty Pharmacy - 800-803-2523 or ESI General Customer Service or by visiting the Express Scripts Website at** https://www.express-scripts.com. Although the cost of the Specialty Pharmacy Copay Assistance Program (the "Program") drugs will not be applied towards satisfying a covered person's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the covered person.

Copays for the specialty medications that are included in this Specialty Pharmacy Copay Assistance Program will be 30% of the cost of the drug. If the manufacturer-funded copay assistance does not cover the copay amount, the Plan will waive the copay.

8. Prescription Drug Management

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies.

Prior Authorization

For certain medications, the Prescription Drug Plan requires a coverage review or "prior authorization" by Express Scripts before benefits will be paid. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan.

The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. To find out whether a medication requires a coverage review, log in to www.express-scripts.com anytime. Prior authorizations, when approved, are typically approved for a one-year period, unless otherwise noted.

Your physician may call Express Scripts at 1-866-281-2409 to request a prior authorization approval

Quantity Level Limits

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact Express Scripts.

Step Therapy Requirements

Step therapy is a program designed to help you save money by using the most cost effective treatments if you have certain health conditions that require maintenance medications. It requires that you try a first line alternative, often a generic medication, to treat your medical condition. Then, based on your doctor's review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization as described in the "Prior Authorization" section fall into this step therapy program. Please contact Express Scripts Member Services at the phone number on the back of your Prescription Drug Identification Card or visit https://www.express-scripts.com for more specific information on the program.

Managed Rx Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by the Plan when presented to the pharmacy provider. Express Scripts may contact the prescribing physician to determine if the prescription drug is medically necessary and appropriate. If it is determined by Express Scripts that the prescription is medically necessary and appropriate, the prescription drug will be dispensed.

B. PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Prescription drugs are covered when you purchase them through the applicable pharmacy network or from a non-participating pharmacy. For convenience and choice, these pharmacies include both major chains and independent stores.

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names and must meet the same FDA requirements.

Each of the tiers in the Prescription Plan has a different copay that applies depending on where you have your prescription filled. The chart below shows your copay amounts, out-of-network coverage, and maximum out-of-pocket amounts.

1. Schedule of Benefits

Pharmacy Network	Retail - National Plus Mail Order – Express Scripts Pharmacy			
Formulary	National Preferred			
Benefit Period	January 1st through December 31st			
Deductible (per benefit period)	None			
Out of Pocket Limit (combined with medical out-of-pocket limit)	UF Direct Health $2,500/ $5,000	BlueCare 65 $5,000/ $10,000	BlueCare 48 $2,500/ $5,000	Blue Options PPO $6,000/ $12,000

	Up to 30-day Supply	Up to 60-day Supply and Express Scripts Home Delivery up to 90-day Supply	Up to 90-day Supply	Out-of-Network
Generic Prescription Drug	$0 copay	$0 copay	$0 copay	50% coinsurance
Brand Formulary Prescription Drug	$40 copay	$80 copay	$120 copay	50% coinsurance
Brand Non-Formulary Prescription Drug	$75 copay	$150 copay	$225 copay	50% coinsurance
Specialty Drug	$75 copay			Not available except as required in an emergency
Generic Substitution	When you purchase a brand drug that has a generic equivalent you may be responsible for the brand drug copay plus the difference in cost between the brand and generic drug unless your physician requests that the brand name drug be dispensed.			
Preventive Medications	Certain preventive medications, including diabetic medications and supplies, may be available with no copay when purchased from a network pharmacy. For additional information and to confirm that a prescription is covered with no copay, please call Express Scripts Member Services at the phone number on the back of your Prescription Drug Identification Card or visit https://www.express-scripts.com.			

C. ELIGIBLE PRESCRIPTION DRUG EXPENSES

1. Covered Drugs

Covered prescription drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary; including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug (drug that requires a pharmacist dispenses it);
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Express Scripts periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics and the U.S. Preventive Services Task Force.

Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto the member website at https://www.express-scripts.com.

- self-injectable medications, other than injectable contraceptives;
- alcohol swabs, when needed for injectable medicines;
- hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- diabetic supplies (such as Chemstrips);
- insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- inhaler assisting devices (eg. Inspirease, Aerochamber)
- adapalene (Differin);
- hemophilia factors;
- Zolgensma;
- allergy extracts (oral only);
- attention deficit disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin);
- oral contraceptives, implantable contraceptives, over-the-counter contraceptives and contraceptive devices (e.g., IUDs, diaphragms and cervical caps);
- all dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.

2. Specialty Medications

Certain drugs are considered "specialty medications" and may only be purchased through a network pharmacy, except as required in an emergency. The following are the therapeutic classifications of specialty medications under the Plan. Please note that this is a summary and not all encompassing.

- Blood Modifiers
- Growth Hormones
- Hemophilia
- IGIV
- Interferon
- Oral Oncologics
- Pulmonary Hypertension
- Other (as determined by the Plan)

For information on ordering specialty medications, dispensing limitations, and your required copay for these drugs, contact Express Scripts by visiting the website at www.express-scripts.com or by calling Member Services at 1-866-281-2409.

3. Brand Name Preferred Formulary Program

The Plan uses a list of prescription drugs called a "formulary."* Certain brand-name medications may not be on the preferred list.

How the formulary works for you:

- Check the list to see if a brand-name drug you use is on the formulary identified on the Schedule of Benefits. Many brand-name medications are included on the formulary. Others might now be available as generics.
- If your brand-name prescription is on the formulary, you'll pay the copay for brand-name Formulary prescriptions.
- If your brand-name prescription is not on the list and you still want to take it, you will need to pay the copay for brand-name non-Formulary prescriptions.

Of course, if a suitable generic is available, you may choose that medication and pay the lower generic copay. Only you and your provider can make decisions about your healthcare. Be sure to ask your doctor about the drugs that appear on your formulary drug list so he or she can choose ones that are right for you.

* Note: Formulary drug lists are updated periodically and subject to change.

D. EXCLUSIONS

Except as specifically provided in this summary plan description, no benefits will be provided for:

- any prescription refilled in excess of the number of times specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- drugs or supplies covered under workers' compensation or occupational disease law or any similar law;
- drugs labeled "caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- drugs and medicines that may not be prescribed within the scope of the doctor's license;
- medication administered in a doctor's office or health care facility (other than contraceptive-related medications);
- prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- pigmenting and depigmenting agents;
- drugs to treat narcolepsy including Provigil;
- vitamins and dietary supplements that require a prescription or that are over the counter;
- fertility drugs, including oral and injectable medication;
- impotency drugs;
- medical foods
- drugs used to treat or cure baldness or hair loss (e.g., minoxidil);
- drugs for weight loss or anti-obesity;
- immunization agents or biological sera;
- injectable supplies (other than for insulin);
- insulin pumps;
- anti-wrinkling agents (e.g., renova);
- drugs used for treatments that are cosmetic-related;
- over-the-counter drugs and products unless specifically listed as covered expenses in the Plan;
- any prescription drug purchased through mail order but not dispensed by the Express Scripts Pharmacy;

Please refer to the Express Scripts national preferred formulary exclusions for the current plan year for a comprehensive list of drugs that are not covered.

E. CLAIMS AND APPEALS

1. General Procedures

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. You will owe the pharmacy any copay or coinsurance that applies. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription. If you use a non-network pharmacy, you will need to submit a claim form yourself.

The procedure is for filing a claim is simple. Just take the following steps.

Know Your Benefits
Review this information to see if the services you received are eligible under your prescription drug program.

Get an Itemized Bill
Itemized bills must include (as applicable):

- The name and address of the service or pharmacy provider;
- The patient's full name;
- The date of purchase;
- The amount charged;
- Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

Complete a Claim Form
To obtain a claim form, call Express Scripts' toll-free Member Services number shown on the back of your Prescription Drug Identification Card or visit https://www.express-scripts.com to access and print claim forms.

You should submit your claim form to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Your claim will be reimbursed according to the type of drug you purchased at an Express Scripts retail pharmacy. If you filled a prescription at a non-participating pharmacy, Express Scripts will then reimburse you for the approved amount minus your applicable deductible and copay or coinsurance.

To find out if your pharmacy is affiliated with Express Scripts, for instructions on filing claims, for refills and for status of an order, call Express Scripts Member Services at the number shown on the back of your Prescription Drug Identification Card.

2. Express Scripts Reviews and Appeals Overview

You must use and exhaust this plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

You have the right to request an initial review for a medication that is not covered at point of sale at either retail or home delivery pharmacies to be covered or to be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called the initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

- Clinical coverage review requests: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the plan. For example, medications that require a prior authorization.
- Administrative coverage review request: A request for coverage of a medication that is based on the plan's benefit design.

How to Request an Initial Coverage Review

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing pharmacist may call the Express Scripts Coverage Review Department at 1-800-753-2851 or the prescriber may submit a completed coverage review form by faxing it to the number provided on the form. Forms may be obtained online at www.express-scripts.com/services/physicians. Home delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filing the prescription.

To request an initial administrative coverage review, you, your doctor or your dispensing pharmacist must submit specific information in writing to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-866-281-2409.

How a Coverage Review Is Processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support his or her request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours**	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful) *
*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.			
** Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.			

Denial Process

An initial coverage/administration review will be denied if the necessary information needed to make a determination is not received from the prescriber within 45 days of the decision timeframe or the information received does not meet the approval standards. An appeal request for further review can be initiated at that point.

3. How to Request Appeals after Coverage Review Has Been Denied

Level 1 Appeal

Upon receipt of a denial notice, a covered member or authorized representative can request a level 1 appeal with Express Scripts within 180 days from receipt of a denial notice. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Description of why the claimant disagrees with the denial

For clinical appeal requests, call/fax/mail to:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588

St. Louis, MO 63166-6588
Phone: 1-800-753-2851 (for expedited requests)
Fax: 1-877-852-4070

For administrative appeal requests, call/fax/mail to:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66588
St. Louis, MO
63166-6588
Phone: 1-800-753-2851 (for expedited requests)
Fax: 1-877-328-9660

Notice of approval or denial will be sent out to you and your prescriber through mail or fax.

Level 2 Appeal
If a level 1 appeal is denied, a request for a level 2 appeal may be submitted by the member or authorized representative to Express Scripts within 90 days from receipt of notice of the level 1 appeal denial notice. You should submit required information to the appropriate address (same as the level 1 appeal shown in the section above).

Alternative Options
You can decide at any time during this process to either pay out of pocket or ask your prescriber for a covered alternative as stipulated in your benefit plan's design.

F. RIGHT OF SUBROGATION AND REIMBURSEMENT

The plan has certain rights to subrogation and reimbursement. Please contact the Trust for more information on the Plan's rights.

G. PRIVACY OF PROTECTION HEALTH INFORMATION

The Trust will use a covered person's protected health information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act") only to make disclosures related to treatment, payment for healthcare, or the Healthcare Operations of the Plan or to make any other disclosures that are required by law. However, if a covered person requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

With respect to PHI, the Trust will:

- Not use or further disclose PHI other than as permitted or required by this Plan Summary or as required by law;
- Ensure that any agent or vendor, to whom the Trust or Plan provides PHI agrees to the same restrictions and conditions that apply to the Trust with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;

- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Trust unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- Make available to the Secretary of the Department of Health and Human Services internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
- Use DHHS approved methods to destroy PHI that is no longer needed.

  In addition, in the event of a breach of unsecured PHI, the Trust will provide written notice or a substitute notice—if the last known contact address is insufficient—for each individual within 60 days following discovery of any breach of Unsecured PHI. The notice will include:
- A brief description of what happened including the date of the breach and the date of discovery, if known;
- A description of the types of unsecured PHI that were involved in the breach;
- Any steps the individual should take to protect himself or herself from potential harm resulting from the breach;
- A brief description of what the Trust is doing to investigate the breach in accordance with HIPAA breach notification requirements;
- Contact procedures for individuals to ask questions or learn additional information

  With respect to Electronic PHI, the Trust will, if PHI is or has been stored on the Trust's computer system:
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or vendor to whom the Trust provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any Breach of Unsecured PHI, once the Breach is known to the agent or vendor or should reasonably have been known to the agent or business associate;
- Report to the Plan any security incident of which the Trust becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

Only Randy Wyse and Randy Reaves may be given access to PHI, and they may use and disclose PHI only for plan administration functions that the Trust performs for the Plan. If either of these persons do not comply with the HIPAA provisions of this Plan Summary, the Trust will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.