

APPENDIX A HEALTH FLEXIBLE SPENDING ACCOUNT

This Appendix A contains the terms and conditions specific to the Health FSA benefit under Section 4.01(A) of the Flexible Benefits Plan. Under the Health FSA Plan a Participant may be reimbursed, on a pre-tax basis, for Qualified Medical Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Flexible Benefits Plan are incorporated into and made applicable to this Health FSA.

ARTICLE A-I MEDICAL REIMBURSEMENT

Section A1.01 Selection of Coverage Option. There are two coverage options available under the Health FSA – the General Purpose Health FSA option and the Limited Purpose Health FSA option. A Participant who elects coverage under the Health FSA will be provided coverage under the General Purpose Health FSA option unless a Participant is contributing money on a pre-tax basis under this Flexible Benefits Plan to an HSA through the service provider set forth on the Schedule of Service Providers, in which event coverage will automatically be provided under the Limited Purpose Health FSA option. The Limited Purpose Health FSA option is not available to a Participant unless he/she is contributing to an HSA as set forth in Appendix H.

Section A1.02 Qualified Medical Expense. The term “Qualified Medical Expense” varies depending on whether coverage is being provided under the General Purpose Health FSA option or under the Limited Purpose Health FSA option:

- (A) **General Purpose Health FSA.** For purposes of this option, “Qualified Medical Expense” means an expense incurred by the Participant or by the Dependent(s) of a Participant (other than the expenses of a Domestic Partner), for medical care as defined in Code § 213(d). The term includes, but is not limited to, amounts paid for hospital bills, doctor and dental bills or prescription medicine and drugs, but does not include reimbursement paid for other health coverage under other plans maintained by the Employer, or reimbursement for over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription.

- (B) **Limited Purpose Health FSA.** For purposes of this option, “Qualified Medical Expense” means an expense incurred by the Participant or by the Dependent(s) of a Participant (other than the expenses of a Domestic Partner), for medical care as defined in Code § 213(d); provided that such expense was incurred only for vision care or dental care. The term does not include reimbursement paid for other health coverage for other plans, such as reimbursement for an expense already reimbursed under the Farm Credit Foundations Dental Plan. The term also does not include reimbursements for over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription. If only a portion of the expense has been reimbursed elsewhere (e.g., because the Dental Plan imposes a co-payment or deductible limitations), then the Limited Purpose Health FSA can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Appendix.

Section A1.03 Reimbursement of Qualified Medical Expenses. The Employer will reimburse the Participant for Qualified Medical Expenses incurred by the Participant during the Plan Year, subject to the other limitations of this Flexible Benefits Plan. For purposes of this Section A1.03, an expense is considered to be “incurred” at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed or charged for the medical care or service. If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Medical Expenses at merchants and service providers that are authorized by the Employer, provided that the claim is properly adjudicated, as set for in A1.07 below.

The Employer will not make any reimbursement to a Participant if the Participant receives reimbursement for the expense through insurance or under any other means. The Employer will not make any reimbursement to a Participant if the expense was incurred before the Participant became a Participant in the Health FSA benefit under the Flexible Benefits Plan or after the Participant ceased to be a Participant in the Health FSA benefit under the Flexible Benefits Plan.

The following expenses constitute reimbursable Qualified Medical Expenses, as defined in A1.02, that may be reimbursed under the two Health FSA options:

(A) **General Purpose Health FSA Option.**

- (1) Deductibles and co-payment amounts paid under medical and/or dental and/or vision care coverage;
- (2) Medical and/or dental and/or vision expenses in excess of usual, reasonable and customary rates; and
- (3) Any other Code § 213(d) medical, dental, or vision expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as Qualified Medical Expenses.

(B) **Limited Purpose Health FSA Option.**

- (1) Services or treatments for dental care (excluding premiums), to the extent they have not been reimbursed by insurance;
- (2) Services or treatments for vision care (excluding premiums), to the extent they have not been reimbursed by insurance;
- (3) Medicines or drugs that (i) meet the definition of Code § 213(d), (ii) are purchased pursuant to a prescription; and (iii) relate to dental care, vision care, or such other purposes as are authorized by the Code, Proposed Treas. Reg. § 1.125-5(m), and any related IRS guidance regarding limited purpose health FSAs; and

- (4) Such other expenses as are authorized by the Code, Proposed Treas. Reg. § 1.125-5(m), and any related IRS guidance regarding limited purpose health FSAs.

The Plan Administrator has discretion to construe and apply what may be reimbursable under this Plan in accordance with such final or informal guidance as the IRS might provide.

Section A1.04 Maximum Amount of Reimbursement. The maximum amount of reimbursement for any Plan Year under the General Purpose Health FSA option is the lesser of \$5,000, or the amount of the Participant's Health FSA. The maximum amount of reimbursement for any Plan Year under the Limited Purpose Health FSA option is the lesser of \$2,500, or the amount of the Participant's Health FSA. A Participant may not carry over an unused amount to a succeeding year. The Employer will reimburse the Participant throughout the coverage period for the total amount the Participant elects to reduce Compensation irrespective of whether the Participant has made sufficient salary reductions to his/her Health FSA.

Section A1.05 Withholding – Accounting. The Employer will establish and maintain a Health FSA for each Participant who has elected to receive the Health FSA benefit under this Flexible Benefits Plan. The Employer will credit to the Participant's Health FSA the amount by which the Participant elects to reduce his/her Compensation. The amounts credited to the Participant's Health FSA are the property of the Employer until the Employer actually makes reimbursement to the Participant. The Employer will debit a Participant's Health FSA for the amount of the reimbursement made for the Participant. A Participant's Health FSA will never exceed the dollar amount specified in Section A1.04 of this Flexible Benefits Plan.

Section A1.06 Year End Accounting – Forfeitures. The Employer will use the amount credited to a Participant's Health FSA for any Plan Year to reimburse the Participant for Qualified Medical Expenses or to make a "qualified reservist distribution" in accordance with Article A-II, Sections A2.06 through A2.09 of this Appendix A. If any balance remains in the Participant's Health FSA for any Plan Year after the Employer has made the Qualified Medical Expense reimbursements and/or the "qualified reservist distributions" for the Plan Year, the Participant will forfeit the unused amount.

Section A1.07 Payment of Medical Expenses. Medical reimbursements shall be processed by the Claims Administrator on at least a weekly basis.

Reimbursement shall be made automatically by the Claims Administrator for those Qualified Medical Expenses for which sufficient information is available from the Farm Credit Foundations Medical Plan or the Farm Credit Foundations Dental Plan to permit the Claims Administrator to determine that the conditions for reimbursement under this Flexible Benefits Plan have been met.

For all other expenses for which reimbursement is desired, the Participant shall be required to apply for reimbursement by completing the application form provided by the Claims Administrator, setting forth:

- (A) The amount, date incurred, and nature of each expense;

- (B) The name of the person, organization, or entity to which the expense was paid;
- (C) The name and date of birth of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;
- (D) The amount (if any) paid under any insurance arrangement or other plan, with respect to the expense; and
- (E) A statement that the expense (or portion thereof for which reimbursement is sought under the Health FSA) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such an application shall be accompanied by an explanation of benefits in the case of a Covered Service or, in the case of a service that is not covered, by a written statement from an independent third party stating the amount of the expense that has been incurred and by such other bills, invoices, receipts, or other statements or documents that the Plan Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

The Employer will directly reimburse the Participant. Subject to Section A2.01 of this Flexible Benefits Plan, a Participant must submit the application for reimbursement for expenses incurred during a Plan Year no later than the March 31 immediately following the end of the Plan Year. The Participant is responsible for keeping copies of all bills, invoices, receipts, or other statements or documents that may be necessary to substantiate the reimbursement of any Qualified Medical Expenses for purposes of his/her own federal tax return.

Section A1.08 Limitation on Reimbursements With Respect to Certain Participants. Notwithstanding any other provision of this Flexible Benefits Plan, the Plan Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated individual (within the meaning of Code § 105(h)(5) or § 125(e)) to the extent the Plan Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section A1.06 of this Flexible Benefits Plan.

Section A1.09 HSA and Health FSA. A Participant may not contribute to a Health Savings Account and participate in the General Purpose Health FSA option (or a similar option under the health FSA of a Spouse) during the same month. In order to contribute to a Health Savings Account and participate in a Health FSA, eligible reimbursements must be of a limited nature or purpose, such as under the Limited Purpose Health FSA option of this Plan where reimbursements are limited to vision and dental expenses. The limitation on the types of expenses that are reimbursable must be by plan design and not determined by the Participant's (or Spouse's) own discretion.

Section A1.10 Claims Procedures. The claims procedures for the Health FSA are set forth in Article VI.

ARTICLE A-II
TERMINATION OF PARTICIPATION IN THE HEALTH FSA

Section A2.01 Termination of Participation in Health FSA Benefit. If a Participant ceases to participate in the Health FSA benefit for any reason, the Participant's election to receive reimbursements for a Qualified Medical Expense terminates on the last day of the pay period in which participation ceases. For example, if a Participant ceases to participate in the Health FSA because he/she terminates employment, his/her participation in the Health FSA shall terminate on the last day of the pay period in which the termination of employment occurs. The Participant may only receive reimbursement for Qualified Medical Expenses incurred within the same Plan Year and prior to the first day after the day the Employee terminates participation in the Health FSA benefit. If a Participant ceases participation in the Health FSA benefit, the Participant must apply for reimbursement in accordance with Article A-I no later than the March 31 immediately following the end of the Plan Year.

Section A2.02 Continuation of Coverage (Other than USERRA). Notwithstanding anything in Section A2.01 of this Flexible Benefits Plan to the contrary and except as provided in Section A2.04 below, an individual who has not overspent his/her account and who has terminated employment may continue to participate in the Health FSA benefit for the remainder of the Plan Year by paying the balance of any amounts necessary for the cost of such Health FSA benefits (i.e., an amount equal to the contribution being made prior to termination plus a reasonable administrative fee) with respect to the remainder of the Plan Year out of the Participant's final paycheck or through monthly contributions to the Employer. A Participant who is on an approved unpaid leave of absence in accordance with the FMLA or otherwise may continue to participate in this Health FSA benefit by:

- (A) Deducting the total amount of the contributions to be due during the leave from the Participant's last paycheck prior to the leave; or
- (B) Suspending contributions during the leave and deducting the total amount of suspended contributions from the Participant's first paycheck upon his/her return to work; or
- (C) Making monthly contributions on an after-tax basis during the leave.

Section A2.03 Limits on Continuation Coverage. Reimbursements shall be made for any Plan Year under Section A2.02 of this Flexible Benefits Plan only if the Participant applies for such reimbursement in accordance with Article A-I no later than the March 31 immediately following the end of the Plan Year. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursement under Section A2.02 of this Flexible Benefits Plan. No reimbursement under Section A2.02 of this Flexible Benefits Plan shall exceed the remaining balance, if any, in the Participant's Health FSA for the Plan Year in which the expenses were incurred.

Section A2.04 USERRA Continuation Rights. Notwithstanding Sections A2.02 and A2.03 above, an individual who terminates participation shall be permitted to continue coverage in this Health FSA as provided under USERRA. Under USERRA, a Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

- (A) **Payment of Premium.** The Participant must pay the applicable premium for any USERRA continuation coverage.
- (B) **Failure to Apply for Reemployment.** Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA.
- (C) **Reasonable Procedures.** The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.
- (D) **Construction and Application.** This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute.

Section A2.05 Electronic Payment Card. A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her Health FSA, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

Section A2.06 Qualified Reservist Distributions ("QRD"). A "qualified reservist distribution" is a distribution of all or a portion of the account balance of a Participant who is called to active military duty, provided the call to active military duty is for a period of 180 or more days or for an indefinite period of time.

Section A2.07 Amount of the QRD. Unless a lesser amount is specifically requested, the QRD will be the total of the Participant's contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

Section A2.08 Time Frame for Requesting a QRD. A Participant must request a QRD on or after the date the Participant is called to active military duty and prior to the March 31st immediately following the Plan Year in which the Participant is called to such duty.

Section A2.09 Time Frame for Plan Administrator to Respond to a Request for a QRD. The Plan Administrator shall respond to any timely request for a QRD within 60 days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Plan Administrator shall follow the claims procedures set forth in Article VI of this Flexible Benefits Plan, except that the time frame set forth in Section 6.04 shall be sixty (60) days instead of ninety (90) days.

Section A2.10 Eligible Claims. A Participant who requests a QRD forfeits the right to receive reimbursements for Qualified Medical Expenses incurred after the date of his/her last day of active employment. Such Participant shall be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the March 31st immediately following the end of the Plan Year and incurred on or prior to the last day of active employment, provided that the total dollar amount of such claims does not exceed the amount of the Participant's election minus the sum of his/her QRD and prior reimbursements received for the Plan Year.

Section A2.11 No Penalty on QRD. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in the Participant's gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

Section A2.12 Effective Date. Sections A2.06 through A2.12 are effective for QRDs requested for a call to active military duty on or after January 1, 2009 (or for a period of active duty beginning prior to January 1, 2009 and continuing on or after such date).

ARTICLE A-III HIPAA MEDICAL PRIVACY AND SECURITY AMENDMENTS

PART I - PREAMBLE

Section A3.01 Purpose and Effective Date. This HIPAA Medical Privacy and Security Amendment ("Amendment") is adopted in response to the provisions of the Medical Privacy and Security Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section A3.02 Application of Amendment. The Flexible Benefits Plan is a "hybrid entity." As such, the Flexible Benefits Plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the Flexible Benefits Plan. This Article A-III shall *only* apply to the Health FSA Plan (hereafter referred to as the "Group Health Plan").

All other benefits provided by the Employer through the Flexible Benefits Plan are either (a) not "group health plans" as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information other than "summary health information," as defined in 45 C.F.R. § 164.504(a), or dis/enrollment information.

This Amendment shall supersede the provisions of the Flexible Benefits Plan to the extent those provisions are inconsistent with the provisions of this Amendment.

Section A3.03 Relationship to Other Group Health Plans. The Flexible Benefits Plan is part of an "organized health care arrangement" ("OHCA") with the following plans sponsored by the Farm Credit Foundations Plan Sponsor Committee:

- (A) The Farm Credit Foundations Medical Plan;
- (B) The Farm Credit Foundations Retiree Medical Plan; and
- (C) The Farm Credit Foundations Dental Plan.

The plans that are part of the OHCA as set forth above may be collectively referred to in this Article A-III as the "Group Health Plan."

[Sections A3.04 through A3.10 are RESERVED for future use.]

PART II – DISCLOSURE OF PHI TO THE EMPLOYER

Section A3.11 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by Part II of this Article A-III, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information or electronic Protected Health Information to the Employer.

Section A3.12 Definitions. For purposes of this Article A-III, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in 45 C.F.R. Parts 160 and 164.

- (A) **"Breach"** means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a "breach."
 - (1) Any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of the Group Health Plan or Business Associate (as defined in 45 C.F.R. § 160.103) if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such employee or individual, respectively, with the Group Health Plan or the Business Associate, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the Privacy or Security Rules;
 - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan or Business Associate to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the Privacy or Security Rules; and
 - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

- (B) **“De-identified Health Information”** means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.
- (C) **“Electronic Media”** means
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
 - (2) Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (D) **“Electronic Protected Health Information” (“e-PHI”)** is PHI that is transmitted or maintained in electronic media.
- (E) **“Individually Identifiable Health Information”** means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;
 - (2) The information relates to the past, present, or future physical or mental health 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; and
 - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

- (F) **“Plan Administration Functions”** means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan that is not part of the same OHCA as the Plan.
- (G) **“Protected Health Information” (“PHI”)** means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (H) **“Security Incident”** (as defined in 45 C.F.R. § 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (I) **“Security Rule”** shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Parts 160 and 164, subpart C.
- (J) **“Summary Health Information”** means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.
- (K) **“Unsecured Protected Health Information” (“Unsecured PHI”)** means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section A3.13 Enrollment/Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled, or has been disenrolled, in the medical coverage provided under the Group Health Plan.

Section A3.14 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (A) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

- (B) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any appeals that are filed with respect to claims that are denied in whole or in part;
- (C) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;
- (D) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;
- (E) Detecting fraud or abuse;
- (F) Determining whether charges for services are appropriate or justified;
- (G) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;
- (H) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;
- (I) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;
- (J) Providing assistance, upon request, to Participants and their covered Dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;
- (K) Reporting corporate finances with respect to current and projected healthcare costs;
- (L) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (M) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section A3.14 is subject to the provisions of Section A3.15.

Section A3.15 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section A3.14, the Employer agrees to do the following:

- (A) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;
- (B) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;
- (C) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (D) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or discloses permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s) and HHS may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;
- (E) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out of pocket in full;
- (F) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in 45 C.F.R. § 164.524;
- (G) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526;
- (H) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528;

- (I) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;
- (J) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (K) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
 - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;
 - (2) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and
 - (3) Report to the Group Health Plan any Security Incident of which it becomes aware.
- (L) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III of this Article A-III; and
- (M) Provide a certification to the Group Health Plan as required by Section A3.16.

Section A3.16 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section A3.15 of Part II of this Article A-III.

[Sections A3.17 through A3.20 are RESERVED for future use.]

PART III - ADMINISTRATIVE SAFEGUARDS

Section A3.21 Adequate Separation Between the Employer and the Plan.

No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III of Article A-III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article A-III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section A3.22 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants: (a) those Employees of the Employer who have the responsibility for administering the benefit programs of the Employer, including, but not limited to, all Employees who serve on or are appointed by the Farm Credit Foundations Trust Committee and all Employees in the benefits section of the Farm Credit Foundations Benefits Department; (b) members of the Farm Credit Foundations Trust Committee; and (c) the Internal Counsel of the Farm Credit Foundations Trust Committee and his/her support staff in the legal department, but only for the limited purposes of ensuring investigation of and responding to complaints alleging violations of the policies and procedures established by the Employer.

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the information technology department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Group Health Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section A3.23 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section A3.24 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III of Article A-III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.