Plan Summary

October 2010

INDIANAVEBA HRA PLAN

A health reimbursement arrangement

This Plan Summary explains how to use your Indiana HRA Plan benefits. It also describes the rights and responsibilities of those covered by the Plan. You and all covered individuals should read and become familiar with its content.

Sign up for direct deposit and e-communication!

Go to **indianahra.com** and click ***my*Indiana HRA *online***.

HRA ADMINISTRATOR, LLC

Indiana HRA Third-party Administrator
Meritain Health
PO Box 27810 I Minneapolis, MN 55427-0810
Phone: 1-888-711-9182 I Claims Fax: (763) 582-3470
E-mail: myIndianaHRA@meritain.com

indianahra.com

IN16 (10/10)

Welcome!

You are now an Indiana HRA plan member. Please carefully read this Plan Summary. It contains important information about how to utilize your member account. It also describes your rights as an Indiana HRA plan member. Please keep this Plan Summary in a safe place for future reference.

If you haven't already done so, sign up for direct deposit and e-communication. Go to indianahra.com and login to your account. After logging in, you can:

- View your account balance
- Track claims in progress
- View claims history
- Submit a change of address
- Update your investment selection(s)
- Update your covered spouse and dependent information
- Print forms

Meritain Health is your Indiana HRA plan's third-party administrator (TPA). The TPA provides customer service, claims processing, and member account administration. Contact the TPA when you have questions related to claims, eligible expenses, spouse/dependent eligibility, etc.

In the event of a discrepancy between this Plan Summary and the actual Plan and Trust documents, the Plan and Trust documents control. The Plan Summary supersedes any previously published Plan informational materials.

Sincerely,
HRA Administrator, LLC
Plan Sponsor

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Indiana HRA Third-party Administrator
Meritain Health
PO Box 27810
Minneapolis, MN 55427-0810
myIndianaHRA@meritain.com
1-888-711-9182

PART I QUESTIONS AND ANSWERS

What is the Indiana HRA Plan?
The Indiana HRA Plan is a health reimbursement arrangement (HRA). Your employer makes tax-free contributions to the Indiana HRA plan on your behalf. The funds are held in a non-profit, tax-exempt voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) § 501(c)(9). You can use these tax-free funds to reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse, and your qualified children and dependents.

What is an HRA?
An HRA is a type of health plan that reimburses qualified out-of-pocket healthcare costs and insurance premiums. All contributions, investment earnings, and withdrawals (claims) are tax-free.

What is a VEBA?
VEBA stands for voluntary employees' beneficiary association and is a tax-exempt trust authorized by Internal Revenue Code Section 501(c)(9).

When and how do I get money out of my HRA account?
Your eligibility to file claims depends upon your employer's plan design. Some plans provide that employees may file claims immediately following enrollment in the program and other plans provide that an employee must separate from service and be vested in all or a portion of their account prior to filing a claim.

When eligible, you may submit an Indiana HRA Claim Form for qualified out-of-pocket medical, dental, or vision expenses incurred by you, your spouse, and/or your qualified children and dependents. Please check with your employer to determine whether or not you may file a claim prior to separation from service. Claims payment is efficient and hassle-free and you may choose direct deposit.

When eligible, you will be sent a claims packet and you may file claims for any amount, but no more than your account balance. Benefits will be paid until your account is exhausted. You may also set up automatic reimbursement or payment of your eligible insurance premiums by submitting a Indiana HRA Systematic Withdrawal Form. If your spouse, children, or dependents are covered by different medical plans, their insurance premiums may also be reimbursed or paid from this account.

Indiana HRA forms may be obtained by logging into your account at **indianahra.com** or by writing:

Indiana HRA Third-party Administrator
Meritain Health
PO Box 27810
Minneapolis, MN 55427-0810

or by calling: **1-888-711-9182**

or e-mail: **myIndianaHRA@meritain.com**

What is a health savings account (HSA) and can I contribute to an HSA?
HSAs are a type of tax-favored medical reimbursement account (your Indiana HRA plan is not an HSA). If you want to make contributions to an HSA, you must meet the contribution eligibility requirements. HSA eligibility requirements are contained in the U.S. Treasury Department's HSA Basics brochure at www.ustreas.gov.

Current IRS rules require that you limit your Indiana HRA plan coverage to permit the reimbursement of only certain types of expenses and insurance premiums as one of the eligibility requirements if you want to make contributions to an HSA. To limit withdrawals from your Indiana HRA account, simply submit a completed and signed Election of Limited Indiana HRA Plan Coverage Form. Or, skip the form and submit your election online. Go to **indianahra.com** and click ***my*Indiana HRA *online*** to login. If you have any questions, please contact the TPA.

What expenses are eligible for reimbursement?
Eligible expenses include qualified medical, dental, and vision expenses not covered by your insurance plans, or medical, dental, vision, Medicare Part B and Part D, Medicare supplement, and tax-qualified long-term care insurance premiums. Purchases made prior to January 1, 2011 of certain over-the-counter drugs, if properly substantiated, qualify for reimbursement. After January 1, 2011, the law permits expenses for over-the-counter drugs (other than insulin) to be reimbursed only if documentation is provided that the drug was prescribed. Eligible expenses are defined in Internal Revenue Code § 213(d). A list of qualified expenses is available after logging in at **indianahra.com** or from the TPA.

Premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's Section 125 cafeteria plan, are not eligible for reimbursement.

Whose expenses are eligible for reimbursement?
Your Indiana HRA plan covers you, your spouse, and any qualified children and dependents. Additional information is available from the TPA.

Can my HRA account automatically reimburse or pay my insurance premiums?
Yes. Simply complete the Indiana HRA Systematic Withdrawal Form and the TPA will reimburse or pay your premium on a systematic basis. Direct deposit is available and recommended.

What happens if I get divorced?
In the event that you become divorced or legally separated, your account cannot be split as part of a property settlement agreement. Contact the TPA for more information on how a divorce or legal separation affects your account.

What if I die before I use up my HRA account?
If you are survived by a spouse or qualified children (or other dependents as defined by the Internal Revenue Code), they may submit requests for medical expense reimbursements until your account is exhausted. If you have no eligible survivors, remaining funds will be reallocated per the instructions in your employer's adoption documents. IRS Revenue Ruling 2006-36 does not permit the payment of benefits to non-dependent heirs.

Is my account vested?
That depends upon your employer's policy or collective bargaining agreement. Please check with your employer to determine any applicable vesting schedule.

When you separate from service, your employer will notify the TPA that you have separated from service and whether or not you are vested. Your vested amount will then be available for you to submit claims to the Plan.

How are my funds invested?
You may choose from among the investment funds listed on the Enrollment Form. You may have your account invested in any combination of the listed investment funds and you may change your investment allocations as often as once each calendar month. An Investment Fund Overview with investment performance history and fund objectives is available and updated quarterly. In addition, you may view up-to-date fund fact sheets and prospectuses on each fund's website which are listed on the Investment Fund Overview.

Will I receive a statement of my account?
Yes. You will receive a quarterly statement detailing all activity in your account and you can sign up for e-communication in lieu of paper (recommended). You may also login to your account online to view account activity, or call or e-mail the TPA and request additional statements at any time. If you have questions about your account, a pending claim, or need claim forms, contact the TPA.

May I view my account information online?
Yes. You may login and view your personal account information online at **indianahra.com** including: account details; investment performance; track the status of claims in progress; view claims history; set up a systematic withdrawal; and update account preferences.

What are the Plan expenses and how are expenses paid?
Plan expenses include costs for the following: third-party administrator, consultant, attorney, printing of plan forms, annual audit, trustee services, investment management, postage, etc. These Plan expenses are paid by fee deductions from member accounts of a flat amount each month and a percentage reduction of investment assets. The fees may vary from employer to employer and will generally range from $0 to $20 per year per member account, plus .38% to 1.0% of assets on an annualized basis. Any applicable per member account fees will be reflected on your quarterly member statement. Investment management costs and other fund expenses are based on the fund(s) selected. Please refer to the Investment Fund Overview to review these expenses.

Who is the HRA third-party administrator (TPA)?
Meritain Health is your Indiana HRA third-party administrator (TPA). Meritain health is an experienced employee benefits administrator and employs a specially-trained service team to assist you. The TPA provides customer service, claims processing, and account administration. Please immediately notify the TPA of any address, name, or systematic withdrawal changes.

Who is the Trustee of the Plan?
Washington Trust Bank in Spokane, Washington is the Trustee of the Plan. The Trustee assists with selection of the investment funds to be made available to Plan Members. Also, the Trustee safeguards and performs periodic valuations of the Plan's assets.

Who is responsible for developing and managing the HRA Plan?
HRA Administrator, LLC, owned by The Variable Annuity Life

Insurance Company (VALIC), is the sponsor of the program and is responsible for plan oversight. VALIC, Meritain Health, and HRA Consultants, A Division of VEBA Service Group, LLC – an experienced HRA VEBA consulting firm – have teamed up to provide you with a program supported by professionals offering the best in local educational services and experienced HRA / VEBA plan administration.

VEBA Service Group, LLC has been administering these types of plans for more than 20 years for governmental employers in the Pacific Northwest and are regarded nationwide as a leader in HRA plan design.

How do I find out more about the plan?
Please contact your local VALIC financial advisor for Plan information. If you have a current account and would like information regarding your account or about filing a claim, please contact the TPA.

Plan Service Providers

Local Service & Plan Education
VALIC Financial Advisors, Inc.
630 W. Carmel Drive, Suite 140
Carmel, IN 46032-9562

Northern Indiana
Amy Cummings
1-317-818-5904
amy.cummings@valic.com
Central & Southern Indiana
Jack Martyn
1-317-818-5940
jack.martyn@valic.com

Trustee
Washington Trust Bank
P.O. Box 2127
Spokane, WA 99210-2127

HRA Third-party Administrator
Meritain Health
PO Box 27810
Minneapolis, MN 55427-0810
1-888-711-9182
myIndianaHRA@meritain.com

Plan Consultant
HRA Consultants, a Division of
VEBA Service Group, LLC
Mark Wilkerson, CFP®
906 West 2nd Avenue, Suite 400
Spokane, WA 99201-4502

PART II OTHER PLAN INFORMATION

The name of the Plan is the State of Indiana Health Reimbursement Arrangement "HRA" Account Plan ("Plan"). The assets of the Plan are held in a trust. Washington Trust Bank has been named trustee.

Washington Trust Bank
Attn: Private Banking
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

This Trust is a voluntary employees' beneficiary association under Internal Revenue Code Section 501(c)(9). The Plan administration is conducted by a third party, Meritain Health, PO Box 27810, Minneapolis, MN 55427-0810, 1-888-711-9182.

The Plan sponsor is HRA Administrator, LLC, 906 West 2nd Avenue, Suite 400, Spokane, WA 99201-4502, Attn: Mark R. Wilkerson, CFP®.

Notice of legal process may be delivered to the Plan Sponsor, Trustee, or the HRA third-party administrator (TPA).

This Plan is provided under collective bargaining agreements or employer policy. Because the benefits for a member in the Plan depend solely on the value of the employer's contribution to the Plan on the member's behalf, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

In the event any Member Account shall have been unclaimed for a period of at least three (3) years since the whereabouts or continued existence of the person entitled thereto was last known to the TPA, the Member Account shall be turned over to whichever State office or department may be entitled to such property under applicable state unclaimed property law.

The Plan year is the 12-month period from January 1 through December 31. Requests for benefits under the Plan must be made in writing to the TPA in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing to the TPA.

PART III PROCEDURE FOR DISPUTED CLAIMS

In the event that a claim for benefits is denied, the following is the procedure for you to appeal a claim:

If your claim is denied in whole or in part, the HRA third-party administrator (TPA) shall notify you of the denial and will include the specific reasons for the denial and specific plan provisions or IRS rules or regulations upon which the denial is based and a description of any material necessary for your claim to be processed. Within 15 days from the date your request for claim was received, the TPA may extend the period by which it expects to render its decision on your claim to a period not to exceed 60 days and shall notify you in writing of the extension.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the TPA. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim request to the TPA.

After the TPA receives your request of an appeal by you or your authorized representative, the TPA shall deliver the complete file to the Plan Sponsor, who shall consider your appeal within 60 days from the time that your request for review was received by the TPA.

In special circumstances, the Plan Sponsor may request a 60-day extension to review the decision. The Plan Sponsor's decision shall be furnished to you and shall include specific reasons for their decision and specific references to pertinent plan provisions or IRS regulations on which the decision was based.

The Plan Sponsor may determine that a hearing is required to properly consider a claim that has been requested for review. In that event, if the Plan Sponsor determines such a hearing is required, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is requested for review.

Claims proceedings set forth in the Plan Summary and in more detail in the Plan Document must be strictly adhered to by each member or other person submitting a claim under this plan and no judicial or arbitration proceedings with respect to any claim for plan benefits shall be commenced by any such member or other person submitting a claim until the proceedings set forth herein have been exhausted in full.

PART IV INVESTMENT FUND INFORMATION

Investment Risk
Accounts invested in stock or bond funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

You should periodically review your selected investment fund choice(s). Should your investment objectives change, you should reevaluate your fund selection(s) and notify the HRA third-party administrator (TPA) in writing of any changes. Remember, there have been numerous loss periods in the past in these types of funds and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, stock or bond investments are suitable primarily as longer-term investments and should not be for short-term use.

Using Multiple Funds
You may have your HRA account allocated to a single fund, two funds, three funds, four funds, or to all available funds.

Transfers
You may transfer among the funds once each calendar month. Transfers are effective within two to three business days.

Withdrawals
If you have multiple funds, benefit withdrawals made from your account will be prorated based on your fund allocation percentage on file with the TPA.

Investment Funds
VALIC Fixed-Interest Option*
Vanguard High-Yield Corporate Admiral
Franklin Total Return A
Columbia US Treasury Index Z
Vanguard Total Bond Market Index Admiral
Vanguard LifeStrategy Growth Investor
Vanguard LifeStrategy Moderate Growth Investor
Vanguard LifeStrategy Conservative Growth Investor
Vanguard Wellington Investor
Vanguard Institutional Index
Vanguard Windsor Investor
Vanguard Mid-Cap Index Investor
Vanguard Small-Cap Growth Index Investor

*A Variable Annuity Life Insurance Company (VALIC) Fixed Annuity (policy form GFUA-398).

Additional Information
Fund fact sheets and prospectuses are available online at **indianahra.com**. You may also view additional information regarding the funds (including performance, risk, holdings, management, fund prospectuses, etc.) on the Internet at:

Franklin Total Return A
www.franklintempleton.com

Columbia US Treasury Index Z
www.columbiafunds.com

Vanguard Funds
www.vanguard.com

Investment Advice
Members are encouraged to seek advice regarding these investment funds from their personal financial advisor. The HRA Plan Sponsor and TPA do not give investment advice.

Investment Expenses
Expenses are expressed as a percent of assets on an annualized basis and are deducted from investment earnings, or if there are no earnings, from member account balances.

COBRA NOTICE

Important information regarding COBRA continuation coverage rights for all participating employees, spouses, and covered children.

Introduction
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides members and those covered by this Plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered children should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the Plan's third-party administrator (TPA), Meritain Health.

General information
A "qualifying event" is an event resulting in the loss of continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as "qualified beneficiaries." Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or member is required to notify the TPA within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage.

Qualifying events
- ***Participating employee.*** If you are a participating employee, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you experience a reduction in hours.
- ***Spouse.*** If you are the spouse of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours; (3) you become divorced or legally separated from employee; or (4) employee passes away.
- ***Children.*** Children of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours; (3) employee and spouse become divorced or legally separated; (4) child reaches age limitation or no longer meets the definition of a qualifying child; or (5) employee passes away.

Qualifying event notification
The TPA will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits.

When the qualifying event is due to an active participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); (2) reduction of hours of employment; or (3) death, the employer must notify the TPA within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the TPA within 60 days of the occurrence of such event, using the Notice of COBRA Qualifying Event form. The Notice must be mailed or hand delivered to the TPA, and is available by request by calling 1-888-711-9182. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation and additional documentation may be required. If the Notice is late, incomplete, or is not submitted as outlined in the Notice of Procedures provided on the aforementioned form, no qualified beneficiary may be offered the opportunity to elect COBRA coverage.

COBRA continuation period
The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA.

COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); or (2) reduction of hours of employment.

A maximum of up to 36 months is allowed when the qualifying event is due to the participating employee's (1) legal separation or divorce; (2) death; or (3) when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension
If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the TPA within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period.

Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of a qualifying child), or death, the covered spouse and/or covered children may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the TPA within 60 days of the occurrence of the second qualifying event.

Information resources
Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to Meritain Health, or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA RIGHTS

If you are on military leave that is governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your qualified dependents may elect to continue contributions to the plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the TPA.

FMLA NOTICE

The Indiana HRA Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your Indiana HRA Plan account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave.

For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

PART VI PRIVACY NOTICE

Introduction
This notice informs you of the ways we may use and disclose medical information about you, and describes our obligations and your rights regarding the use and disclosure of medical information.

This notice also describes how you can access such information. Please review carefully. Questions should be directed to the Plan's third-party administrator (TPA), Meritain Health, at **1-888-711-9182** or **myindianahra@meritain.com**.

Who will follow this notice
The plan is structured so that your medical information is administered and maintained solely by the Plan's TPA, and neither the Plan, the Plan Sponsor, nor your Employer will create or receive medical information except for summary health information for limited purposes and enrollment/disenrollment information. The TPA and any other third party that assists in the administration of Plan claims are required by law and by contract with the Plan to follow this notice.

Privacy pledge
Medical information about you and your health is personal, and we are committed to protecting it. A record of your healthcare claims reimbursed under the Plan is kept for administration purposes only. This notice applies to all medical records we maintain.

We are required by law to (1) make sure medical information identifying you is kept private; (2) make sure that information stored or transmitted in electronic form is secure; (3) provide this notice of our legal duties and privacy/security practices concerning medical information about you; and (4) follow the terms of the notice currently in effect.

How we may use and disclose medical information about you
The following categories describe various ways we use and disclose medical information. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- ***For payment (as described in applicable regulations).*** We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from healthcare providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your healthcare provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share medical information with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.
- ***For healthcare operations (as described in applicable regulations).*** We may use and disclose medical information about you for other Plan operations necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.
- ***As required by law.*** We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.
- ***To avert a serious threat to health or safety.*** We may use and disclose medical information about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.
- ***Special situations: Military and veterans.*** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate

foreign military authority.

- ***Workers' compensation.*** We may release medical information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.
- ***Public health risks.*** We may disclose medical information about you for public health activities such as to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).
- ***Health oversight activities.*** We may disclose medical information to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- ***Lawsuits and disputes***. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.
- ***Law enforcement.*** We may release medical information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- ***National security and intelligence activities.*** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- ***Inmates.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your rights regarding medical information about you

You have the following rights regarding medical information we maintain about you.

- ***Right to inspect and copy.*** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit a written request to the TPA. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.
- ***Right to amend.*** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the TPA including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- ***Right to an accounting of disclosures.*** You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or healthcare operations. This includes any unauthorized access, use, disclosure, modification, or destruction of electronic medical information or any interference with an information system handling such information. To request an accounting of disclosures, you must submit a written request to the TPA stating a specific time period, which may not be longer than six years, and may not include dates before Plan participation began. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free; you may be charged for additional lists. We will notify you of any charge and you may choose to withdraw or modify your request before any costs are incurred.
- ***Right to request restrictions.*** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, healthcare operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. To request restrictions, you must submit a written request to the TPA detailing (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e., your spouse).
- ***Right to request confidential communications.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the TPA specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.
- ***Right to a paper copy of this notice***. You have the right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. To obtain a paper copy of this notice, contact the TPA.

Changes to this notice

We reserve the right to change this notice and make the revised notice effective for medical information we already have about you

as well as any information we receive in the future.

Future revised notices will be delivered and made available to members via one or more of the following methods: e-mail; regular mail; in the Plan Summary available online after logging in to ***my*IndianaHRA *online***; and by request to the TPA.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the TPA's compliance officer at (716) 319-5500. You will not be penalized for filing a complaint.

Other uses of medical information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

PART VII MEDICARE PART D NOTICE OF NONCREDITABLE COVERAGE

To members, spouses, children and dependents eligible or becoming eligible for Medicare. Important notice regarding your prescription drug coverage under this Plan and Medicare Part D.

Introduction
Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006.
You may have heard about Medicare's prescription drug coverage and wondered how it will affect you. Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage.
Prescription drug coverage provided by this Plan is limited to your available account balance and is considered "non-creditable." In other words, coverage provided by this Plan is, on average for all plan members, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll.
Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, children, or dependents are currently Medicare eligible, you need to make a decision.
The terms of this Plan will not change if you choose to enroll in a Medicare prescription drug plan. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources
More detailed information about Medicare plans that offer prescription drug coverage is contained in the *Medicare & You* handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by: (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for telephone numbers); or (3) calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at anytime from the TPA.

PART VIII

COORDINATION OF BENEFITS WITH MEDICARE

Coordination of Benefits with Medicare.
If you are entitled to Medicare and are claims eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare. To comply with federal law you should file your claims in accordance with these primary and secondary payer rules.

- If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have an active, claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have an active, claims eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting.
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA plans for plan years beginning on or after October 1, 2010, requires the TPA for your HRA account to report specific information about Medicare beneficiaries who have other group coverage (such as your HRA coverage). To comply with this federal law, the policies and procedures of the TPA will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims in your HRA account. In addition, in submitting claims for reimbursement or coverage under your HRA account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact the TPA or you can call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.