SAN FELIPE DEL RIO CISD
HEALTH INDEMNITY PLAN

Plan Document and Summary Plan Description
Effective: January 1, 2022

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ARTICLE I
ESTABLISHMENT AND ADOPTION OF THE PLAN

THIS IS THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION for the **San Felipe Del Rio CISD Health Indemnity Plan** ("Health Indemnity Plan").

1.1 Adoption of Plan and Effective Date

The Health Indemnity Plan is adopted and administered by the **San Felipe Del Rio Consolidated Independent School District** ("Employer"). The managing body of the Employer may designate a committee, or specific individuals, to carry out the day-to-day operations of the Plan which is known as the "Plan Administrator." The Plan is effective as of January 1, 2022 ("Effective Date").

The purpose of this Health Indemnity Plan is to provide reimbursement for certain "Covered Services" which are covered medical expenses under the **San Felipe Del Rio CISD Group Health Plan** (the "Group Health Plan"). This Health Indemnity Plan is offered to Employees who are eligible under the **San Felipe Del Rio CISD Group Health Plan** ("Group Health Plan") but have declined coverage under the **Group Health Plan.**

The Health Indemnity Plan is funded with contributions made by the Employer from its general assets.

1.2 Purpose

This is a limited scope Plan.

This Health Indemnity Plan is offered as an alternative to benefits provided under the Group Health Plan. It provides benefits only for Covered Services as outlined in the Schedule of Medical Benefits. If the service is not a covered benefit under the Group Health Plan, it is not available to you under this Health Indemnity Plan.

1.3 No Contributions

The Employer does not charge a fee to participate in this Health Indemnity Plan.

1.4 Right to Amend or Terminate

The Employer intends to maintain this Health Indemnity Plan indefinitely. However, the governing body of the Employer reserves the right to terminate, suspend, discontinue or amend the Health Indemnity Plan at any time and for any reason. No oral interpretations can change this Indemnity Plan. Changes in the Health Indemnity Plan may occur in any or all parts of the Health Indemnity Plan. If the Health Indemnity Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment, or elimination.

Should you have any questions regarding the terms of the Health Indemnity Plan, your eligibility or benefits, you may contact the Kempton Care Advocate toll free at (800) 324-9396 or your Human Resources Department.

1.5 Definitions

All definitions specific to this Health Indemnity Plan are listed herein. However, certain definitions not listed below are specifically defined in the Group Health Plan. To the extent a defined term is included within a definition which has been incorporated by reference, but which is not specifically listed in this Article, such term shall also be incorporated by reference and made a part hereof, as if fully set forth herein.

In the event of an inconsistency between the Group Health Plan definitions and those contained in this Health Indemnity Plan, the definitions in this Health Indemnity Plan will prevail only to the extent that the definitions relate to benefits available under this Health Indemnity Plan.

"***Group Health Plan***" means the San Felipe Del Rio CISD Group Health Plan.

"***Health Indemnity Plan***" means the San Felipe Del Rio CISD Health Indemnity Plan.

*"**Covered Services**"* means the medical services which are eligible for the daily reimbursement as outlined in the Schedule of Medical Benefits. Only those services also defined under the Group Health Plan as a Covered Charge are eligible for reimbursement under the Health Indemnity Plan.

"***Kempton***" means The Kempton Group Administrators, Inc. which is responsible for assisting the Plan Administrator to help you utilize this Health Indemnity Plan.

*"**Plan Administrator***" means the committee or individual designated by the Employer with responsibility for the administration of the Plan. The Plan Administrator has full and complete discretion to interpret the terms of this Health Indemnity Plan.

*"**Kempton Care Advocate***" means the representative at The Kempton Group Administrators, Inc. who will assist you with questions, help you determine if the medical expense is a Covered Service under this Health Indemnity Plan.

ARTICLE II
GENERAL PROVISIONS

2.1 Eligibility
The eligibility for employees under this Health Indemnity Plan is determined by the eligibility requirements set forth in the Group Health Plan. If you declined coverage through the Group Health Plan and meet the eligibility requirements, you are a Covered Person under this Health Indemnity Plan. Dependents are not eligible for coverage under the Health Indemnity Plan.

2.1A Eligibility for Dental Indemnity Plan
Only employees covered under the Health Indemnity Plan may elect coverage under the Dental Indemnity Plan. Dependents are not eligible for coverage under the Dental Indemnity Plan.

2.2 Effective Date of Coverage
Coverage under the Health Indemnity Plan is effective on the first day of active employment following the notification of declination of coverage under the Group Health Plan. Coverage under the Dental Indemnity Plan, if elected, is effective on the same date that you have coverage under the Health Indemnity Plan.

2.3 Benefits
This Health Indemnity Plan provides benefits only for Covered Services to Covered Persons who are eligible under the Health Indemnity Plan.

This Health Indemnity Plan will pay benefits only for the medical expenses incurred while you are actually covered under the Plan. No benefits are payable for expenses incurred before your coverage begins or after your coverage is terminated.

ARTICLE III
GROUP HEALTH PLAN PROVISIONS

The following provisions of the Group Health Plan are incorporated into this Health Indemnity Plan by reference. These rules apply to this Health Indemnity Plan in the same manner that they apply to the Group Health Plan unless otherwise stated herein.

3.1 Eligibility and Effective Dates of Coverage and Termination in Group Health Plan

The Group Health Plan provides information regarding eligibility, how to enroll, when coverage begins, and when you can change or reinstate your coverage.

This Health Indemnity Plan is sponsored as an alternative plan which provides benefits in lieu of those offered through the Group Health Plan. If you declined coverage under the Group Health Plan you have coverage under this Plan. You may not elect the benefits of this Plan by a separate election.

Refer to the Group Health Plan to determine eligibility, effective dates of coverage, and termination of coverage under this Health Indemnity Plan.

This **Health Indemnity Plan** does not offer an independent right to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The **Dental Indemnity Plan**, if elected, offers an independent right to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). It is important for you to follow the provisions of the Group Health Plan to determine when you have a right to continue coverage under the Dental Indemnity Plan and that you make timely elections to retain such coverage. If you are a COBRA participant under the Dental Indemnity Plan, you are entitled to benefits under this Dental Indemnity Plan. If you do not make a timely election for continuation coverage under the Dental Indemnity Plan, you will not have any right to retain coverage under this Dental Indemnity Plan.

3.2 Medical Benefits in Group Health Plan

The reimbursement available to you under the Health Indemnity Plan is only eligible if the expense is for a Covered Service under the Group Health Plan. This Plan is not subject to the utilization requirements for network providers listed therein. This Health Indemnity Plan does not include any vision or prescription drug benefits.

3.3 Limitations and Exclusions in Group Health Plan

If a service is listed as excluded under the Group Health Plan, it is also excluded under this Health Indemnity Plan. To the extent they describe procedures or services which are not covered, such provisions are incorporated by reference. All the general limitations and exclusions apply to this Health Indemnity Plan.

ARTICLE IV
SUMMARY OF BENEFITS

The benefits provided under this Health Indemnity Plan are the limited to only those Covered Services listed in the Schedule of Medical Benefits.

4.1 Schedule of Medical Benefits

SCHEDULE OF MEDICAL BENEFITS	
All Inpatient Hospital Stays for Covered Services	$200 per day for each inpatient stay

4.2 Requirements of this Health Indemnity Plan

In order to obtain reimbursement under this Health Indemnity Plan, you must adhere to the following procedures:

1. You must submit a self-pay claim form to the Claims Administrator. This form can be obtained at www.kemptongroup.com.

2. You must include an itemized bill along with the self-pay claim form to the Claims Administrator. The itemized bill must include the following:

    a. Group name;
    b. Employee/Patient's name and ID number;
    c. Name, address, telephone number of the provider of care;
    d. Provider of care tax identification number and National Provider Identification (NPI) number;
    e. Type of services rendered, with diagnosis and procedure codes;
    f. Date of services; and
    g. Charges.

3. The self-pay claim form and itemized bill must be submitted within 12 months of the date charges for the services were Incurred.

Claims should be filed as soon as possible with the Claims Administrator. Claims must be filed with the Claims Administrator within 12 months of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

ARTICLE V
DENTAL INDEMNITY BENEFITS

This employee-only benefit is only available to Employees enrolled in the Health Indemnity Plan and who have elected the Dental Indemnity benefits. This benefit applies when covered dental charges are Incurred by a person while covered under this Plan.

The dental benefits are a limited scope dental plan. In accordance with Department of Labor (DOL) Regulation 2590.732(c)(3), it is not an integral part of the medical plan. ***The dental benefits shall be considered as "excepted benefits" for purposes of ACA and HIPAA.*** Dental benefits are not subject to the mandates that apply under ACA including, but not limited to, the annual limitations, the out-of-pocket limitations and the Essential Health Benefit requirements. All limitations set forth for dental benefits apply separately from those set forth in the medical provisions of the Plan. Eligible Employees may decline dental coverage.

5.1 Schedule of Dental Benefits

Schedule of Dental Benefits	
Annual Maximum Benefit Per Person	$1,500
Dental Deductible Per Person	$75
Deductible Accumulation Period	Calendar Year
Dental Deductible Requirement The Dental Deductible is applicable to all Covered Dental Expense in the aggregate except for expenses for Class A charges – Diagnostic and Preventive Care.	

Dental Percentage Payable	
Class A Diagnostic and Preventive Treatments	80%
Class B Basic Restorative Treatments	80%
Class C Major Restorations, Bridgework, and Dentures	50%

5.2 Deductible

Each Covered Person has a Dental Deductible each Calendar Year. The Dental Deductible is applicable to all Covered Dental Expenses in the aggregate except for expenses for Class A charges: Diagnostic and Preventive Care.

Deductible Amount. This is an amount of money for dental charges which the Covered Person must pay before the dental plan pays any benefits. Each Calendar Year, the Covered Person must meet the Deductible shown in the Schedule of Dental Benefits before the dental plan begins payment of any benefits.

5.3 Benefit Payment

Each Calendar Year benefits will be paid for the Covered Person for the dental charges in excess of the Deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Dental Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

5.4 Maximum Benefit Amount

The maximum dental benefit amount is shown in the Schedule of Dental Benefits.

5.5 Dental Charges

Dental charges are the Usual and Customary Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is Incurred on the date the service or supply for which it is made is performed or furnished.

5.6 Covered Dental Services

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services.

1. Routine oral exams. Limit of two per Covered Person per Calendar Year.
2. Oral Prophylaxis (preventative and periodontal) limited to two per Calendar Year.
3. Bitewing x-ray series. Limited to two bitewing series per Calendar Year.
4. One full mouth x-ray once every five years.
5. Fluoride treatment. Limited to two per Calendar Year.
6. Space maintainers for missing primary posterior teeth.
7. Emergency palliative treatment for pain.
8. Sealants, limited to permanent 1st & 2nd molars, once per tooth in a 60-month period.

Class B Services: Basic Dental Procedures

1. Dental x-rays not included in Class A.
2. Oral surgery. Oral surgery is limited to removal of teeth, removal of impacted teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
3. Periodontics (gum treatments).
4. Endodontics (root canals).
5. Extractions, except extractions for orthodontics or of sound teeth. This service includes local anesthesia and routine post-operative care.
6. Recementing bridges, crowns, or inlays.
7. Fillings, other than gold.
8. General anesthetics, upon demonstration of Medical Necessity.
9. Antibiotic Drugs.
10. Stainless steel crowns.
11. Root canal therapy.
12. Pulpal therapy.
13. Emergency palliative treatment for pain.

Class C Services: Major Dental Procedures

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Porcelain or cast restorations.
3. Implants.
4. Osseous surgery.
5. Installation of crowns.
6. Installation of onlays.
7. Installing precision attachments for removable dentures.
8. Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made within 12 months following the installation.
9. Addition of clasp or rest to existing partial removable dentures.
10. Initial installation of non-cosmetic dental implants, fixed bridgework, partials or full removable dentures to
    replace one or more natural teeth extracted after the effective date of coverage.
11. Repair of crowns, bridgework, and removable dentures.
12. Rebasing or relining of removable dentures allowed once in 36 months.

13. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth after the effective date of coverage. However, this item will apply only if one of these tests is met:
    a. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
    b. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

5.7 Exclusions

A charge for the following is not covered:

1. **Administrative Costs.** Administrative costs of completing claim forms or reports or for providing dental records.

2. **Appliance.** Appliance to control harmful habits including nightguard/occlusal guard.

3. **Athletic Mouthguards.**

4. **Broken Appointments.** Charges for broken or missed dental appointments.

5. **Complications of Non-covered Treatments.** Services that are required as a result of complications from a treatment not covered under the Plan are not covered.

6. **Cosmetic.** Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

7. **Duplicate X-Rays.**

8. **Error.** Services required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

9. **Excess.** Services that are not payable under the Plan due to application of any Plan maximum, or limit or because the charges are in excess of the Usual and Customary amount or are for services not deemed to be Reasonable or Dentally Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

10. **Excluded under Medical.** Services that are excluded under the General Limitations and Exclusions section.

11. **Experimental.** Services that are Experimental or Investigational.

12. **Extractions.** Expenses for extractions of sound teeth.

13. **Family Member.** Services performed by a person who is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in-law."

14. **Government.** Expenses to the extent paid, or which the Covered Person is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

15. **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

16. **Illegal Acts.** Any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

17. **Incomplete Billings.** Charges contained in statements that are incomplete. The documentation submitted by a Covered Person must include itemized statements identifying the patient, date of treatment, diagnosis and type of service provided, and charge for each service. Examples of unacceptable statements are photocopies, cash register receipts, canceled checks and similar documents.

18. **Incurred by Other Persons.** Expenses actually Incurred by other persons.

19. **Medical Necessity.** Services that are not medically or dentally necessary.

20. **Medical Services.** Services that, to any extent, are payable under any medical expense benefits of the Health Indemnity Plan.

21. **Myofunctional Therapy. E**xpenses for myofunctional therapy or correction of harmful habits.

22. **Negligence.** Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

23. **No Charge.** Services for which there would not have been a charge if no coverage had been in force.

24. **No Legal Obligation.** Services that are provided to a Covered Person for which the Provider of a service customarily makes no direct charge, or for which the Covered Person is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or this benefit plan, *may be liable* for necessitating the fees, care, supplies, or services.

25. **No Listing.** Services which are not included in the list of covered dental services.

26. **Non-Medical/Dental Care.** Expenses Incurred in connection with Custodial Care, education, or training.

27. **Non-Medical/Dental Charges.** For copy fees or similar charges that are not directly related to the treatment of a Sickness or Injury.

28. **Not Acceptable.** Services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

29. **Not Actually Rendered.** Services that are not actually rendered.

30. **Not Specifically Covered.** Service that are not specifically covered under this Plan.

31. **Occupational.** Care and treatment of an Injury or Sickness that is occupational - that is, arises from work for wage or profit including self-employment.

32. **Orthodontia.** Orthodontic treatment and orthognathic surgery.

33. **Orthognathic Surgery.** Surgery to correct malposition in the bones of the jaw.

34. **Plan Design.** Charges excluded or limited by the Plan design as stated in this document.

35. **Prohibited by Law.** Expenses to the extent that payment under this Plan is prohibited by law.

36. **Replacement or Repairs.** Replacement or repairs of lost or stolen prosthetic devices or appliances.

37. **Self-Inflicted.** Expenses Incurred as the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

38. **Services at Employer's Premises.** Expenses for services rendered through a medical department clinic or similar facility provided or maintained by the Participating Employer.

39. **Services Before or After Coverage.** Expenses Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

40. **Services Not Provided by Dentist or Physician.** Expenses for treatment by other than a Dentist or Physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed by a Dentist.

41. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are Cosmetic.

42. **Sterilization.** Expenses related to sterilization.

43. **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) syndrome.

44. **Travel or Accommodations.** Travel or accommodations, whether or not recommended by a Physician, except for ambulance charges when defined as a Covered Charge.

45. **Veneers.** Expenses related to veneers.

46. **Vitamins.** Expenses related to vitamins.

47. **War.** Expenses Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

ARTICLE VI
LIMITATIONS AND EXCLUSIONS

6.1 General Exclusions and Limitations

The services which are excluded under "Limitations and Exclusions" of the Group Health Plan are excluded from this Health Indemnity Plan.

ARTICLE VII
ERISA DISCLOSURES

7.1 Plan Information

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") requires that the following information be provided to you.

Formal Name of Plan: San Felipe Del Rio CISD Health Indemnity Plan

Plan Name as Commonly Known to Participants: Health Indemnity Plan

Employer Identification Number: 74-1694073

Plan Number: This is an alternative benefit to plan number 501.

Type of Administration: This is a self-funded plan administered directly by the Plan Administrator. Benefits are provided by the Plan with claims being processed for the San Felipe Del Rio Consolidated Independent School District by The Kempton Group Administrators, Inc.

Plan Administrator:
San Felipe Del Rio Consolidated Independent School District
315 Griner Street
Del Rio, TX 78840
830-778-4014

Claims Administrator:
The Kempton Group Administrators, Inc.
13431 Broadway Ext., Suite 130
Oklahoma City, OK 73114
Fax: 405-521-9804
www.kemptongroup.com

Agent for Service of Legal Process:
San Felipe Del Rio Consolidated Independent School District
315 Griner Street
Del Rio, TX 78840
830-778-4014

Purpose of the Plan. The purpose of the Health Indemnity Plan is to provide for limited reimbursement of certain Covered Expenses Incurred as a result of Illness or Injury to the eligible Employees.

Contributions and Dividends. The cost of the Plan is borne by the Employer. The Employer does not charge a separate fee for you to participate in this Plan.

Plan Year. The plan year is the twelve month period beginning January 1 and ending on the last day of December each year.

7.2 Claims Procedure

In order to obtain reimbursement under this Health Indemnity Plan, you must adhere to the follow procedures:

1. You must submit a self-pay claim form to the Claims Administrator. This form can be obtained at www.kemptongroup.com.

2. You must include an itemized bill along with the self-pay claim form to the Claims Administrator. The itemized bill must include the following:

a. Group name;
b. Employee/Patient's name and ID number;
c. Name, address, telephone number of the provider of care;
d. Provider of care tax identification number and National Provider Identification (NPI) number;
e. Type of services rendered, with diagnosis and procedure codes;
f. Date of services; and
g. Charges.

3. The self-pay claim form and itemized bill must be submitted within 12 months of the date charges for the services were Incurred.

Claims should be filed as soon as possible with the Claims Administrator. Claims must be filed with the Claims Administrator within 12 months of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

7.3 Appeals

This Health Indemnity Plan adheres to the Claims Procedure outlined in the Group Health Plan.

ARTICLE VIII
RIGHTS OF PARTICIPANTS UNDER ERISA

As a participant in this Health Indemnity Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

8.1 Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specification locations, such as work sites and union halls, all documents governing this Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Because this is an add-on benefit to the Group Health Plan, the annual returns of the Group Health Plan include this Plan.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. The report you receive for the Group Health Plan includes the information for this Plan as well.

8.2 Continue Group Health Plan Coverage

This is a limited scope health plan which is an alternative to the Group Health Plan. It is not subject to the continuation of health care coverage.

8.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

8.4 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator (your employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

8.5 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Benefits Administration. U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE IX
HIPAA PRIVACY

9.1 Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Administrator and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;

2. The Covered Person's privacy rights with respect to his/her PHI;

3. The Plan's duties with respect to his/her PHI;

4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and

5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

9.2 How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;

2. For Health Care Operations;

3. For Treatment purposes; or

4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities**).**

9.3 Disclosure of PHI to the Plan Administrator for Plan Administration Purposes

In order that the Plan Administrator may receive and use PHI for plan administration purposes, the Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 *et seq.);*

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Administrator becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Administrator, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Administrator, shall be given access to the PHI to be disclosed:
        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Administrator performs for the Plan.
    b. In the event any of the individuals described in the above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

9.4 Disclosure of Summary Health Information to the Plan Administrator

The Plan may disclose PHI to the Plan Administrator of the Health Indemnity Plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Administrator for obtaining premium bids or modifying, amending, or terminating the Health Indemnity Plan.

9.5 Disclosure of Certain Enrollment Information to the Plan Administrator

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Administrator information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Administrator.

9.6 Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Administrator may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

9.7 Other Disclosures and Uses of PHI

Primary Uses and Disclosures of PHI:

1. **Treatment, Payment and Health Care Operations.** The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. **Business Associates.** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

3. **Other Covered Entities.** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

9.8 Other Possible Uses and Disclosures of PHI

1. **Required by Law.** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. **Public Health and Safety.** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and

d. a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. **Government Authority.** The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. **Health Oversight Activities.** The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. **Lawsuits and Disputes.** The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. **Law Enforcement.** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. **Decedents.** The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. **Research.** The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. **To Avert a Serious Threat to Health or Safety.** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. **Workers' Compensation.** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. **Military and National Security.** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

9.9 Required Disclosures of PHI

1. **Disclosures to Covered Persons.** The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an

individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person.

2. **Disclosures to the Secretary of the U.S. Dept. of Health and Human Services.** The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

9.10 Rights to Individuals

The Covered Person has the following rights regarding PHI about him/her:

1. **Request Restrictions.** The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. **Right to Receive Confidential Communication.** The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

3. **Copy of this Notice.** The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. **Accounting of Disclosures.** The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.

5. **Access.** The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

6. **Amendment.** The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

9.11 Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan Administrator using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:
Compliance Officer
The Kempton Group Administrators, Inc.
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114

ARTICLE X
HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Administrator for Plan Administration Functions.

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

10.1 Definitions

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

10.2 Plan Administrator Obligations

To enable the Plan Administrator to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Administrator agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Administrator, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Administrator provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

10.3 Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

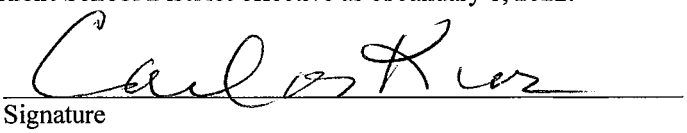
2. Notify the media if the breach affecting affects more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

IN WITNESS WHEREOF, the **San Felipe Del Rio CISD Health Indemnity Plan** is adopted as stated herein, by authority of its manager or its duly designated party, executed on behalf of **San Felipe Del Rio Consolidated Independent School District** effective as of January 1, 2022.

By: 

Signature

Carlos H. Rios

Printed Name

Superintendent of Schools

Title

January 3, 2022

Date