FUNDED HEALTH REIMBURSEMENT ARRANGEMENT
BASIC PLAN DOCUMENT

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ARTICLE I.
INTRODUCTION

1.1 **Establishment.** An executed Adoption Agreement plus this Basic Plan Document constitute the "Plan." The effective date of the Plan is set forth in the Adoption Agreement.

1.2 **Purpose.** The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for certain Eligible Expenses as provided in this Plan. It is the intention of the Adopting Employer that the benefits provided and payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Sections 105(b) and 106 of the Code. In addition, it is the intention of the Adopting Employer that the Plan qualify as a Health Reimbursement Arrangement ("HRA") under IRS Revenue Ruling 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

1.3 **HIPAA Privacy and Security Rules.** This Plan is a "covered entity" for purposes of the Privacy Rules and Security Rules as described in greater detail in Article VII below.

1.4 **Not ERISA Plan**. This Plan is not an employee welfare benefit plan for purposes of ERISA.

1.5 **Trust.** This Plan is funded through a Trust, reflected in a separate document.

ARTICLE II.
DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 **Adopting Employer** means the entity that adopts this Plan by completing and executing an Adoption Agreement.

2.2 **Adoption Agreement** means the separate agreement, or portions thereof, completed and executed by an Adopting Employer setting forth the Adopting Employer's selection of options under the Plan.

2.3 **Authorized Representative** means, for the claims and appeal procedures, the person entitled to act on behalf of the claimant with respect to a benefit claim or appeal. In order for the Plan to recognize a person as an Authorized Representative, written notification to that affect signed by the claimant and notarized must be received by the Plan. An assignment for purposes of payment is ***not*** designation of an "Authorized Representative."

2.4 **Basic Plan Document** means this document, which together with an executed Adoption Agreement constitutes the Plan for an Adopting Employer.

2.5 **Claims Administrator** means the person or entity designated by and under contract with the Plan Administrator to perform certain administrative functions, including, but not limited to, claims administration and recordkeeping.

2.6 **Claims Run-out Period** means the period of time following the end of a Plan Year (Section 4.3) or the termination of a Participant's participation in the Plan (Section 4.7) during which the Participant may submit claims to the Plan for expenses incurred during the Plan Year or the Participant's participation (as the case may be).

2.7 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.8 **Covered Individual** means a Participant, Dependent of a Participant and the Spouse of a Participant, and any other person appropriately covered under the Plan.

2.9 **Dependent** means as defined in the Adoption Agreement.

2.10 **Employee** means any person employed by the Adopting Employer and on the Employer's W-2 payroll on or after the Effective Date. Employee does not include the following:

(a) Any self-employed individual as described in Section 401(c) of the Code;

(b) Any employee included within a unit of employees covered by a collective bargaining agreement unless such agreement expressly provides for coverage of the employee under this Plan;

(c) Any employee who is a nonresident alien and receives no earned income from the Adopting Employer from sources within the United States;

(d) Any employee who is a leased employee as defined in Section 414(n)(2) of the Code;

(e) An individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; and

(f) Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

2.11 **Employer Contribution** means a nonelective contribution made by the Adopting Employer on behalf of each Participant in accordance with Section 5.1. The Employer Contribution is an amount that has not been actually or constructively received by the Participant, and it is made available to the Participant exclusively for reimbursement under the Plan. Employer Contributions may include mandatory salary reduction contributions.

2.12 **Entry Date** means the date as of which an Employee becomes a Participant in this Plan as set forth in the Adoption Agreement.

2.13 **ePHI** means PHI maintained or transmitted in electronic media, including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.14 **ERISA** means the Employee Retirement Income Security Act of 1974 and regulations thereunder, as amended from time to time. Plans sponsored by public sector entities are not subject to ERISA.

2.15 **HC Account** means "health care account" and is the record keeping account established under the Plan for each Participant.

2.16 **Health Care Expense** means as defined in the Adoption Agreement, provided it is defined no more broadly than the description in IRS Revenue Ruling 2002-41 and IRS Notice 2002-45. Notwithstanding the foregoing, if the Adopting Employer sponsors a cafeteria plan, Health Care Expense shall not include premiums that may be paid on a pre-tax basis in accordance with the terms of such cafeteria plan, which may include premiums for major medical coverage provided by the Employer and premiums for coverage under an insurance contract, health maintenance organization agreement, or other benefit agreement providing coverage issued on a non-group, individual basis. To the extent Health Care Expense is defined in the Adoption Agreement to include premiums for qualified long-term care insurance, the amount of such premium that will qualify as a Health Care Expense shall be limited to the portion that constitutes "eligible long-term care premiums" as defined in Section 213(d)(10) of the Code. "Health Care Expense" may include over-the-counter drugs and medicine (other than insulin) only if such drug or medicine has been prescribed, as required by Section 106(f) of the Code. Notwithstanding the foregoing, if the Plan is an integrated HRA and the group medical plan in which a Participant is enrolled does not provide at least 60% minimum value, then, during the period of time in which such a Participant is receiving contributions to the Plan, Health Care Expense for such a Participant shall be defined no more broadly than allowed under applicable law. "Health Care Expense" shall not include premiums for a medical insurance policy issued in the individual insurance market or through a public exchange. The forgoing restriction on the eligibility of individual medical insurance premiums shall be effective as of the first Plan Year beginning on or after January 1, 2017, provided such expenses were eligible Health Care Expenses under the Plan prior to December 16, 2015. Health Care Expenses are sometimes referred to herein as "Eligible Expenses."

2.17 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder, as amended from time to time.

2.18 **Health Reimbursement Arrangement ("HRA")** means the Employer-funded medical reimbursement program within the meaning of IRS Revenue Ruling 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

2.19 **Highly Compensated Individual** means an individual who is (1) one of the 5 highest paid officers, or (2) among the highest paid 25 percent of all Employees, except (i) Employees who have not completed 3 years of service, (ii) Employees who have not attained age 25, (iii) part-time or seasonal Employees, (iv) Employees not included in the plan who are included under a collective bargaining agreement, and (v) Employees who are nonresident aliens and who receive no earned income from a source within the United States.

2.20 **Limited Scope Health Care Expense** means, unless provided otherwise in the Adoption Agreement, a Health Care Expense for dental or vision care that qualifies as an expense for medical care under Section 213(d) of the Code. "Limited Scope Health Care Expense" may include over-the-counter drugs and medicine only if such drug or medicine has been prescribed, as required by Section 106(f) of the Code. Limited Scope Health Care Expenses are sometimes referred to herein as "Eligible Expenses."

2.21 **Managing Body** means the person or persons with authority to make decisions for the Adopting Employer.

2.22 **Participant** means any Employee (or former Employee) who is or may become eligible to receive a benefit through this Plan. In addition, Participant includes persons "deemed" to be Participants under a specific provision of this Plan.

2.23 **PHI** means health information that:

(a) Is created or received by a health care provider, health plan, or health care clearinghouse;

(b) Relates to the past, present, or future physical or mental health or condition of an individual (including "genetic information" as that term is defined in the Genetic Information Nondiscrimination Act of 2008); the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(c) Either identifies the individual or reasonably could be used to identify the individual.

2.24 **Plan** means this Plan as may be amended from time to time. It consists of a completed Adoption Agreement plus the Basic Plan Document. The name of the Plan is specified in the Adoption Agreement.

2.25 **Plan Administrator** means the entity, person or persons determined under Section 8.1.

2.26 **Plan Year** means the twelve (12) month period beginning and ending as indicated in the Adoption Agreement. The initial Plan Year may be a "short" Plan Year beginning and ending as indicated in the Adoption Agreement. The records of the Plan will be kept based upon the Plan Year.

2.27 **Privacy Rules** means the *Standards of Privacy of Individually Identifiable Health Information* at 45 C.F.R. part 160 and part 164 at subparts A and E.

2.28 **Security Incident** means "security incident" as defined in 45 C.F.R. Section 164.304, which generally defines "security incident" to include attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI.

2.29 **Security Rules** means the Security Standards and Implementation Specifications at 45 C.F.R. Part 160 and Part 164, subpart C.

2.30 **Spouse** means "Spouse" as defined in the Adoption Agreement.

2.31 **Trust** means the trust identified in the Adoption Agreement, created for the purpose of accepting and holding Employer Contributions, and limited other contributions, made under the Plan.

2.32 **Trustee** means the trustee of the Trust.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION OF EMPLOYEES

3.1 **Eligibility Requirements.** Each Employee shall be eligible to participate in this Plan upon meeting the eligibility requirements set forth in the Adoption Agreement.

3.2 **Participant Status.** An Employee who has met the eligibility requirements described in Section 3.1 shall become a Participant as of the Employee's Entry Date.

3.3 **Conditions of Participation.** As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Claims Administrator and Plan Administrator with respect to any provider of services involved in a claim under this Plan;

(c) Submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Claims Administrator and Plan Administrator may reasonably require; and

(d) Cooperate with all reasonable requests of the Claims Administrator and Plan Administrator that may be necessary for the proper administration of the Plan.

Failure to comply with the foregoing conditions relieves the Plan, Plan Administrator, Claims Administrator, and Adopting Employer of any obligations under this Plan with respect to that Participant and any others claiming entitlement to benefits under this Plan through that Participant and shall result in the termination of the Participant's participation in the Plan.

3.4 **Coverage Options.** The Plan consists of one or more of the following coverage options as described below.

(a) One or more of the following coverage options, as indicated in the Adoption Agreement, are available under the Plan:

(i) **Full Scope Option.** Participants may receive reimbursement for Health Care Expenses incurred by themselves and their Spouses and Dependents, provided that a Spouse or Dependent's Health Care Expenses are reimbursable only if that Spouse or Dependent is enrolled in the Adopting Employer's group medical plan or, if provided in the Adoption Agreement, that Spouse or Dependent is enrolled in another employer's group medical plan and the Participant provides an attestation of that fact. The foregoing restriction on reimbursement of Health Care Expenses shall be effective as of the first Plan Year beginning on or after January 1, 2017 provided such expenses were eligible expenses under the Plan prior to December 16, 2015.

(ii) **Limited Scope Option.** Participants may receive reimbursement for only Limited Scope Health Care Expenses incurred by themselves and their Spouses and Dependents.

(iii) **Suspended Account Option.** Participants may receive no reimbursements from their HC Accounts. However, the balance of the Participant's HC Account will be

preserved for use in subsequent Plan Years.

(b) Participants will be covered under the "Full Scope Option" unless the Participant elects in writing and in a manner specified by the Plan Administrator to participate in another available coverage option. Notwithstanding the foregoing, if provided in the Adoption Agreement, Participants enrolled in a high deductible health plan (as defined in Section 223 of the Code) sponsored by the Adopting Employer shall automatically be enrolled in the coverage option specified in the Adoption Agreement. If an election of coverage options is required, such an election shall be effective on a Plan Year basis, shall be made prior to the beginning of the Plan Year, shall be irrevocable during the Plan Year, and shall automatically renew for subsequent Plan Years unless the Participant makes an election (in the manner specified above) to participate in a different coverage option for such subsequent Plan Year. Notwithstanding the foregoing, the Plan Administrator may allow an election of a coverage option mid-year when a Participant enters the Plan mid-Plan Year, the Plan is amended mid-Plan Year to include an additional coverage option, or the Adopting Employer makes changes to its group medical plan (e.g., adds a high deductible health plan) mid-Plan Year.

(c) If a Participant changes coverage options, the following rules apply with respect to claims for reimbursement under the Plan:

(i) Expenses will be eligible for reimbursement under the Plan in accordance with the coverage option in which the Participant is enrolled at the time the expense is incurred. For example, if a Participant who is enrolled in the "Limited Scope Option" incurs an expense for something other than a Limited Scope Health Care Expense, that expense cannot be reimbursed under the Plan at any time in the future (e.g., if the Participant subsequently becomes covered under the "Full Scope Option").

(ii) Notwithstanding the foregoing, unless provided otherwise in the Adoption Agreement, a Health Care Expense incurred while the Participant is covered under the "Full Scope Option" will not be reimbursed if the claim for such expense is submitted after the Participant has become covered under another coverage option and such expense is not reimbursable under the new coverage option. For example, if a Participant incurs an expense for something other than a Limited Scope Health Care Expense while covered under the "Full Scope Option," that expense cannot be reimbursed if the claim is submitted after the Participant becomes covered under the "Limited Scope Option."

3.5 **Waiver of Participation.** A Participant may elect to permanently waive future participation in and reimbursements under this Plan (the "opt out election"). The opportunity to make an opt out election will be made available annually and upon termination of the Participant's employment with the Adopting Employer. An opt out election shall be made in accordance with procedures established by the Plan Administrator. If the opt out election is made during the election opportunity provided annually, the opt out election will be effective as of the last day of the Plan Year in which it is made. If the opt out election is made during the election opportunity provided upon termination of employment, the opt out election will be effective on the date specified in the Adoption Agreement. If a Participant makes an opt out election, no reimbursements will be provided by the Plan to that Participant for Eligible Expenses incurred after the effective date of the opt out election. However, unless otherwise prohibited by applicable law (including regulatory guidance), a Participant making an opt out election may continue to submit claims for Eligible Expenses incurred prior to the effective date of the opt out election until the close of the applicable claim Claims Run-out Period. Furthermore, if provided in the Adoption Agreement, a Participant's

opt out election shall expire upon the close of the Plan Year for which the election was made and the Participant's prior HC Account balance (as of the time of the opt out election minus subsequent reimbursements) shall be reinstated on the first day of the subsequent Plan Year, provided however that the Participant may renew his/her opt out election for such Plan Year in accordance with the procedures established by the Plan Administrator.

3.6 **Termination of Contributions.** Unless provided otherwise in the Adoption Agreement, a Participant shall cease to be eligible to receive contributions under this Plan at midnight of the earliest of the following dates:

(a) The date of the death of the Participant;

(b) The date of termination of the Participant's employment with the Adopting Employer;

(c) The date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time in accordance with Article IX; or

(d) The date of termination of the Plan in accordance with Article IX.

Termination of contributions under this Plan shall not prevent a former Participant from receiving continuation coverage required by applicable law.

3.7 **Termination of Participation.** Unless provided otherwise in the Adoption Agreement, a Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:

(a) The date of the termination of the Participant's employment with the Adopting Employer;

(b) The date of the death of the Participant;

(c) The date the balance of the Participant's HC Account reaches zero, if no further contributions will be made to said account under Article V; or

(d) The date of termination of the Plan in accordance with Article IX.

Participation may also terminate for cause, including for failing to comply with the conditions of participation described in Section 3.3 and/or for making fraudulent or improper claims. In certain cases, if participation is terminated for cause, the Participant's coverage may be terminated retroactively to the date on which the event giving rise to the cause occurred. Termination of participation in this Plan shall not prevent a former Participant from receiving continuation coverage required by applicable law.

ARTICLE IV.
BENEFITS UNDER THE PLAN

4.1 **Benefits.** The Plan shall reimburse Eligible Expenses in accordance with Section 3.4 and this Article IV.

4.2 **Health Care ("HC") Account.** The HC Account will be credited with the Employer Contribution. A Participant's HC Account will be decreased from time to time in the amount of payments made to the Participant for Eligible Expenses.

4.3 **Claims for Reimbursement.** A Participant may obtain reimbursement of Eligible Expenses by submitting a paper claim or through an electronic payment card as described below.

(a) **Paper Claims**. A Participant may make a claim by completing a claim form and submitting such form to the Claims Administrator setting forth at least the following:

(1) the amount, date and nature of the expense, including the identity of the individual who incurred the expense;

(2) the name of the person or entity to which the expense was paid or is owed;

(3) the Participant's statement that the expense has not been reimbursed and the Participant will not seek reimbursement for the expense; and

(4) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by such bills, invoices, receipts, explanations of benefits ("EOB") issued by a health plan, or other statements from an independent third party as is necessary to establish that an Eligible Expense has been incurred and the amount of the expense. The Claims Administrator is entitled to rely on the information provided on the claim form in processing claims under this Plan. A claim must be submitted for payment within the time period indicated in the Adoption Agreement. Where circumstances beyond the Participant's control prevent submission within the described time frame, notice of a claim with an explanation of the circumstances may be accepted by the Claims Administrator as a timely filing. Claims shall be determined in accordance with Article VI.

(b) **Electronic Payment Card.** A Participant may receive reimbursement of an Eligible Expense by use of an electronic payment card at the time the Eligible Expense is incurred. The use of the electronic payment card shall be subject following conditions:

(1) The electronic payment card will be deactivated when a Participant's participation in the Plan terminates.

(2) The balance of the electronic payment card shall be limited to 90% of the balance of the Participant's HC Account.

(3) A Participant must certify in writing prior to issuance of the electronic payment card that:

(i) the electronic payment card will be used only for Eligible Expenses that have not been reimbursed under any other plan covering similar benefits; and

(ii) the Participant will not seek reimbursement for any expense paid with the electronic payment card under any other plan covering benefits.

The electronic payment card shall include a statement providing that each use of the card shall constitute a reaffirmation of the certification.

(4) The electronic payment card may be used only at merchants who are health care providers (e.g., doctor's office, hospital, pharmacy, etc.) or other merchants identified in applicable IRS guidance.

(5) Each time the electronic payment card is used, a Participant shall obtain and retain a third party statement from the health care provider containing the information necessary to substantiate that the expense paid by the card was an Eligible Expense.

(6) Claims shall be substantiated if one of the following conditions is satisfied:

(i) The Participant provides, upon request by the Claims Administrator (or its designee), the third party statement with respect to the claim.

(ii) The payment was made to a merchant who is a health care provider and it matches a specific co-payment the Participant has under a group medical or group dental plan sponsored by the Adopting Employer or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment.

(iii) The payment was made to a merchant who is a health care provider and is for an expense with the same amount, duration, and health care provider as a previously approved expense under this Plan.

(iv) The payment was made to a merchant who is a health care provider and the electronic claim file with respect to the expense is accompanied by an electronic or written confirmation from the health care provider that verifies the nature and amount of the expense and that the expense is an Eligible Expense.

(v) The electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(7) Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin. Notwithstanding the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:

(i) At any 90% pharmacy if the expense is substantiated after the purchase in accordance with paragraph (6)(i) above.

(ii) At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (a) the cardholder presents the prescription to the

pharmacist; (b) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (c) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (d) the pharmacy's records are accessible by the employer or its agent; (e) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (f) the expense is substantiated in accordance with the standard rules described above in paragraph (6).

(iii) At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with the standard rules described above in paragraph (6).

(8) A Participant shall repay the Plan for a payment with respect to any claim not substantiated (and therefore not eligible for reimbursement) as required above. The Plan shall handle unsubstantiated claims as required under the Code and applicable regulations.

(9) The use of an electronic payment card does not constitute a "claim" under the claims procedures.

4.4 **Incurred Expenses.** An expense is "incurred" when the Participant is provided with the care giving rise to the Eligible Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses. To be reimbursable, the Participant must have incurred an Eligible Expense after his/her Entry Date.

4.5 **Timing of Reimbursement.** For claims made via a paper claim, Participants shall be reimbursed weekly.

4.6 **Maximum Reimbursement.** The maximum reimbursement a Participant may receive at any time shall be the amount of the Participant's HC Account balance at the time the reimbursement request is processed. The maximum reimbursement requirements apply to the Participant, Spouse, and Dependents on an aggregate basis, not an individual basis. Notwithstanding the foregoing, in order to accommodate fluctuations in the market value of the assets in which an HC Account is invested, the Plan Administrator (or its designee) may limit the amount of reimbursements a Participant may receive to 90% of the Participant's HC Account balance at the time the reimbursement request is processed. If a Participant's claim is for an amount that is more than the maximum described above, the excess, unreimbursed part of the claim will be pended and paid as the balance of the Participant's HC Account becomes adequate. Notwithstanding the foregoing, the excess, unreimbursed portion of a claim will not be pended if the HC Account has been exhausted and no further contributions will be made to the Participant's HC Account under Article V.

4.7 **Termination of Participation.**

(a) **Termination of Employment.** Notwithstanding anything herein to the contrary, a Participant will have the rights described in the Adoption Agreement when he/she terminates employment with his/her Employer (other than upon death) with a balance in his/her HC Account. If the Adoption Agreement indicates the balance of the Participant's HC Account will be transferred to another HRA, the Plan Administrator may establish procedures for facilitating the transfer of the HC Account to the other HRA, including procedures related to reimbursement of Eligible Expenses incurred prior to the Participant's

termination of employment.

(b) **Death.**

i. Notwithstanding anything herein to the contrary, if a Participant incurred an Eligible Expense prior to his/her death that would have been reimbursable by the Plan but that has not been submitted for reimbursement, the deceased Participant's estate may submit such Eligible Expense for reimbursement in accordance with Section 4.3(a). A certified copy of the deceased Participant's death certificate and proof that the person acting upon behalf of such Participant's estate has authority to do so must be submitted with such claims.

ii. Notwithstanding anything herein to the contrary, if a Participant has a surviving Spouse or Dependents at the time of his/her death, such surviving Spouse and Dependents will have the rights described in the Adoption Agreement with respect to the balance of the Participant's HC Account. If the Adoption Agreement indicates the surviving Spouse and Dependents shall have access to the Participant's HC Account or the balance of the HC Account will be transferred to another HRA, no such access or transfer will occur unless and until a certified copy of the deceased Participant's death certificate has been provided to the Claims Administrator. The Plan Administrator may establish additional procedures for facilitating the access by the surviving Spouse and Dependents or the transfer of the HC Account to the other HRA, including procedures related to reimbursement of Eligible Expenses incurred prior to the Participant's death.

iii. Notwithstanding anything herein to the contrary, if a Participant does not have a surviving Spouse or Dependent but does have a Designated Beneficiary at the time of his/her death, the Participant's Designated Beneficiary will have the rights described in the Adoption Agreement with respect to the balance of the Participant's HC Account. If the Adoption Agreement indicates the Designated Beneficiary shall have access to the Participant's HC Account or the balance of the HC Account will be transferred to another HRA, no such access or transfer will occur unless and until a certified copy of the deceased Participant's death certificate has been provided to the Claims Administrator and the Designated Beneficiary has certified that the Participant does not have a surviving Spouse or Dependent. The Plan Administrator may establish additional procedures for facilitating the access by the Designated Beneficiary or the transfer of the HC Account to the other HRA, including procedures related to reimbursement of Eligible Expenses incurred prior to the Participant's death. If provided in accordance with the Adoption Agreement, reimbursements paid to a Designated Beneficiary shall be reported as taxable income to the Designated Beneficiary to the extent required by law. For purposes of the Plan, a "Designated Beneficiary" is a person designated by a Participant as his/her beneficiary in accordance with the procedures established by the Claims Administrator for doing so. A Participant may designate one or more contingent Designated Beneficiaries who will become a Designated Beneficiary if the primary Designated Beneficiary predeceases the Participant. An individual who is the Participant's Spouse or Dependent is not a Designated Beneficiary even if the Participant has attempted to designate his/her Spouse or Dependent as a beneficiary.

4.8 **Nondiscrimination.** This Plan is intended to be nondiscriminatory and to meet the nondiscrimination requirements under applicable sections of the Code. If the Plan Administrator or an Employer determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Individuals, the Plan Administrator or Employer shall take such action as the Plan Administrator or Employer deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitation.

4.9 **HC Account Forfeitures.** Unless provided otherwise in the Adoption Agreement and subject to the provisions of Section 4.7, any amount remaining in a Participant's HC Account shall be forfeited following the later to occur of: (1) the termination of Participant's participation in the Plan (including, but not limited to, the Participant's election to opt out under Section 3.5), (2) the termination of any continuation coverage provided by the Plan under applicable law, or (3) the termination of any other coverage provided by the Plan in accordance with Section 4.7. Notwithstanding the forgoing, a Participant's HC Account shall also be forfeited if: (i) the balance of the HC account is less than $25, (ii) no further contributions shall be made to the HC Account, and (iii) no claim has been submitted by the Participant for a period of six (6) months. In addition, the portion of the Participant's HC Account that is not vested shall be forfeited upon the Participant's termination of employment. Forfeited amounts shall be used for the purposes described in the Adoption Agreement. However, except as allowed under the Trust, no amounts will revert to the Adopting Employer. If the Adoption Agreement indicates that forfeitures shall be contributed to the HC Accounts of other Participants, the following rules shall apply. Forfeitures occurring during a Plan Year shall be held in a separate subaccount until the close of the Plan Year. Immediately following the close of the Plan Year, the forfeitures shall be contributed to the HC Accounts of all Participants employed by the Adopting Employer on the last day of such Plan Year in the manner provided in the Adoption Agreement (i.e., on a per capita or pro rata basis). To the extent the full balance of the forfeiture subaccount cannot be allocated as provided in the Adoption Agreement (e.g., because the balance does not divide evenly among the number of Participants), any balance remaining shall be held in the forfeiture subaccount until the end of the subsequent Plan Year and allocated at that time.

4.10 **Medical Support Orders.** Notwithstanding any provision of this Plan to the contrary this Plan shall recognize medical child support orders as required under applicable state law or under the Child Support Performance and Incentive Act of 1998. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Plan Administrator.

4.11 **Coordination with Cafeteria Plan.** To the extent the Adopting Employer also sponsors a medical reimbursement program as part of its cafeteria plan within the meaning of Section 125 of the Code, a Participant participates in the medical reimbursement program, and the Participant or a Covered Individual covered through such a Participant incurs an Eligible Expense that is also eligible for reimbursement under the medical reimbursement program, which program pays first is described in the Adoption Agreement.

4.12 **Further Limitations on Benefits**.

(a) This Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Adopting Employer or by the Participant, the

Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

(d) Other limitations, if any, as set forth in the Adoption Agreement.

ARTICLE V.
CONTRIBUTIONS AND TRUST

5.1 **Employer Contributions**. The Adopting Employer shall make a fixed contribution per Participant as set forth in the Adoption Agreement. The amount of the Employer Contribution, and any restrictions on the use thereof, shall be identified in the Adoption Agreement and communicated to the Participants. The amount of the Employer Contribution may change from time to time as reflected in the Adoption Agreement.

5.2 **No Employee Contributions**. Except for contributions required for continuation coverage, no contributions other than Employer Contributions are required nor will they be accepted.

5.3 **Trust**. All contributions shall be held in the Trust. The investment of the assets of the Trust shall be directed as provided in the Adoption Agreement. Notwithstanding the foregoing, the investment of any assets of the Trust that constitute forfeitures shall be directed by the Plan Administrator until such time, if any, that such forfeitures are allocated to the HC Accounts of other Participants.

ARTICLE VI.
CLAIMS DETERMINATIONS AND REVIEW OF DENIED CLAIM

The following procedures apply:

6.1 **General Provisions.** All claims and appeals will be adjudicated in a manner so that the independence and impartiality of the persons involved in making the determination are ensured. Decisions regarding hiring, compensation, termination, and similar matters with respect to any individual involved in the determination (e.g., a claims adjudicator or medical expert) shall not be based upon the likelihood that the individual will support a denial of benefits.

6.2 **Initial Claim Determination.**

(a) **Time Frame for Decision**. The Plan must determine the claim within thirty (30) days of receipt of the claim.

(b) **Extension of Time**. If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to fifteen (15) days to determine the claim. If this additional time will be needed, the Plan must notify the claimant or the claimant's Authorized Representative prior to the expiration of the initial thirty (30) day time period for determining the claim. This extension is only available once.

> **Notification**: The notification of the need for the extension must include a description of the "matters beyond the Plan's control" that justify the extension and the date by which a decision is expected.

(c) **Incomplete Claims**. There is no special rule if a claim is incomplete. Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the claimant is appropriately notified, the Plan's period of time to make a decision is "tolled."

> **Tolling**: The period of time in which the Plan must determine a claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the claimant responds.

> **Notification**: For this purpose, notification can be made orally to the claimant or the health care professional, unless the claimant requests written notice. The notification will include a time frame in which the necessary information must be provided. Once the necessary information has been provided, the Plan must decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be decided without that information.

6.3 **Decision.**

(a) **Notification of Decision**. Written (or electronic) notification of the Plan's determination must be provided to the claimant or the claimant's Authorized Representative. Such notification must be provided only where the decision is adverse. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 45 CFR § 147.136, to the extent such regulation applies to the Plan.

"**Adverse**" means:

- A denial, reduction, or termination of a benefit;
- A failure to provide or make payment (in whole or in part) for a benefit; or
- A rescission of coverage under the Plan, which is a cancellation or discontinuance of coverage under the Plan that has retroactive effect other than a cancellation or discontinuance attributable to a failure to timely pay or make required premiums or contributions toward coverage.

(b) **Adverse Decision**. For adverse claim determinations, the notification shall at a minimum:

- Include information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, and the claim amount, and to inform the claimant of the right to receive, upon request, the diagnosis and treatment codes (if any) and their corresponding meanings upon request;
- State the specific reason(s) for the determination, including the denial code (if any) and its corresponding meaning, and describe the Plan's standard, if any, used to make the determination;
- Reference specific Plan provision(s) upon which the determination is based;
- Describe additional material or information necessary to complete the claim and why such information is necessary;
- Describe the internal appeals and external review processes (if any) available under the Plan, including how to initiate an appeal and the procedures and time limits applicable to an appeal;
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- Where the decision involves scientific or clinical judgment, disclose either (1) an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances, or (2) a statement that such explanation will be provided at no charge upon request; and
- Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes (if any).

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(c) **Not Adverse Decision**. For claim determinations that are not adverse, notice will be provided that informs the claimant or the claimant's Authorized Representative the claim has been accepted.

6.4 **Access to Relevant Documents.**

In order (1) to evaluate whether to request review of an adverse determination, and (2) if review is requested, to prepare for such review, the claimant or the claimant's Authorized Representative will have access to all relevant documents.

Relevant: A document, record or other information is "relevant" if it was relied upon in making the determination, or was submitted to the Plan, considered by the Plan, or generated in the course of making the benefit determination without regard to whether it was relied upon.

6.5 **Appealing a Denied Claim.**

If a claim is denied, in whole or part, the claimant or the claimant's Authorized Representative may request the denied claim be reviewed.

(a) **Requesting Review**. The claimant or the claimant's Authorized Representative has a period of one-hundred eighty (180) days to appeal the claim determination. The appeal request must be in writing and should be sent to the address specified in the notification of adverse decision described above.

(b) **Full and Fair Review.** The clamant will have the right to review the claim file and to present evidence and testimony. The claimant will be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date. Before the Plan issues a final internal adverse benefit determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determined is required to give the claimant a reasonable opportunity to respond prior to that date. The review of the adverse benefit determinations will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(c) **Consultation with Independent Medical Expert**. In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted, if any, during the initial determination or a subordinate of that individual.

Disclosure: If the advice of a medical or vocational expert was obtained by the Plan in connection with the claim denial, the names of each such expert shall be provided, regardless of whether the advice was relied upon.

(d) **Time Frame for Decision**. If claimant or the claimant's Authorized Representative requests a review of a denied claim within the time frame described above, the Plan Administrator shall review the claim and make a determination no later than sixty (60) days from the date the review request was received.

(e) **Decision**. The review of the claim will be conducted by the Plan Administrator. It will be made by a person different from the person who made the initial determination and such person will not be a subordinate of the original decision maker. The information in the administrative record shall be reviewed. Additional information submitted shall be

considered. The decision shall be based upon that information plus the terms of the Plan and past interpretations of the same and similar Plan provisions. The Plan may rely upon protocols, guidelines, or other criterion.

(f) **Notification of Decision**. Written (or electronic) notification of the Plan's determination must be provided to the claimant or the claimant's Authorized Representative. Such notification must be provided whether the decision is adverse or not adverse. The notification will be provided in a culturally and linguistically appropriate manner in accordance with 45 CFR § 147.136, to the extent such regulation applies to the Plan.

"**Adverse**" means:

- A denial, reduction, or termination of a benefit;
- A failure to provide or make payment (in whole or in part) for a benefit, or
- A rescission of coverage under the Plan, which is a cancellation or discontinuance of coverage under the Plan that has retroactive effect other than a cancellation or discontinuance attributable to a failure to timely pay or make required premiums or contributions toward coverage.

(g) **Adverse Decision**. For adverse appeal determinations, the notification shall reflect at least the following:

- Include information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, and the claim amount, and to inform the claimant of the right to receive, upon request, the diagnosis and treatment codes (if any) and their corresponding meanings upon request;
- Contain a discussion of the determination, including the specific reason(s) for the determination, the denial code (if any) and its corresponding meaning, and the Plan's standard, if any, used to make the determination;
- Reference specific Plan provision(s) upon which the determination is based;
- Describe the external review process (if any) available under the Plan;
- Disclose any internal rules, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- Where the decision involves scientific or clinical judgment, disclose either (1) an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances, or (2) a statement that such explanation will be provided at no charge upon request; and
- Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the external review process (if any).

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(h) **Not Adverse Decision**. For claim determinations that are not adverse, notice will be provided that informs the claimant or the claimant's Authorized Representative the decision

has been reversed, and the claim accepted.

6.6 **Deemed Exhaustion.** If the Plan fails to adhere to the requirements described in 45 CFR § 147.136(b)(2), the claimant will be deemed to have exhausted the internal claims and appeals process as provided in 45 CFR § 147.136(b)(2)(ii)(F), to the extent such regulation applies to the Plan.

6.7 **External Review.** The Plan will provide any applicable external review process that may be required to be provided by a health reimbursement arrangement under 45 CFR § 147.136, to the extent such regulation applies to the Plan.

ARTICLE VII.
HIPAA PRIVACY AND SECURITY PROVISIONS

The Privacy Rules and Security Rules under HIPAA apply to the Plan.

7.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent allowed by, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Adopting Employer in accordance with this Article VII, the Adopting Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Adopting Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by Adopting Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Adopting Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefits claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities, and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan); and

(13) Reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administration activities of the Plan, including, but not limited to:

a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

b. Customer service, including data analyses for policyholders;

(8) Resolution of internal grievances; and

(9) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

7.2 **Adopting Employer's Obligations under the Privacy Rules.** Under the Privacy Rules, the Plan may not disclose PHI to the Adopting Employer unless the Adopting Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Adopting Employer that the Plan has been amended to

include certain conditions to the Adopting Employer's receipt of PHI and that Adopting Employer agrees to those conditions. By adopting this Plan document, the Adopting Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Adopting Employer. The Adopting Employer agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Adopting Employer with respect to such PHI;

(c) Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Adopting Employer unless authorized by an individual;

(e) Report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) Make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

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

7.3 **Adopting Employer's Obligations under Security Rules.** If the Adopting Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Adopting Employer will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) Ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) Report to the Plan any Security Incident of which it becomes aware; and

(d) Implement reasonable and appropriate security measures to ensure that only those persons identified in Section 7.4 have access to ePHI and that such access is limited to the purposes identified in Section 7.5.

7.4 **Adequate separation between the Plan and the Adopting Employer must be maintained**. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) the person employed in the position that is given primary responsibility for performing the Adopting Employer's duties as the Plan Administrator of the Plan; and

(b) staff designated by the person described in (a) above.

7.5 **Limitation of PHI and ePHI Access and Disclosure**. The persons described in Section 7.4 above may only have access to, and use and disclose, PHI and ePHI for Plan administration functions that the Adopting Employer performs for the Plan.

7.6 **Noncompliance Issues**. If the person(s) described in Section 7.4 above does not comply with this Plan document, the Adopting Employer shall provide a mechanism for resolving issues of noncompliance, including, but not limited to, disciplinary action against such person.

ARTICLE VIII.
PLAN ADMINISTRATION

8.1 **Plan Administrator**.

(a) The Plan Administrator shall be responsible for the general supervision of the Plan and shall have authority to control and manage the operation and administration of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

(b) The Adopting Employer shall be the Plan Administrator unless its Managing Body designates a person or persons other than the Adopting Employer to be the Plan Administrator. The Adopting Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator.

(c) The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, and/or responsibilities regarding the operation and administration of this Plan.

8.2 **Plan Administrator Absolute Authority**. Any and all questions or controversies of whatever character, arising in any manner in connection with the Plan or the operation thereof, shall be submitted to the Plan Administrator and shall be considered and determined by the Plan Administrator. The Plan Administrator shall have the sole and absolute discretion to construe and interpret the Plan, including but not limited consideration of any and all of the provisions, rules, regulations, or procedures used to interpret the Plan. Benefits under the Plan shall be paid only if the Plan Administrator determines in its sole and absolute discretion that the claimant is entitled to such benefits. To the extent any Plan Administrator duties are delegated to others, the Plan Administrator retains the ultimate right and responsibility, in its sole and absolute discretion, to ultimately decide all appeals. Any exercise by the Plan Administrator (or its delegate) of the Plan Administrator's sole and absolute discretionary authority with respect to the construction and interpretation of the Plan, including but not limited to eligibility for coverage and entitlement to benefits, shall be final and binding.

8.3 **Agent for Service of Legal Process.** The agent for service of legal process for the Plan is the Plan Administrator.

8.4 **Allocation of Responsibility for Administration.** The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of an Employee of the Adopting Employer. Neither the Plan Administrator nor the Adopting Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

8.5 **Rules and Decisions.** Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the

Adopting Employer, or legal counsel, or other entity acting on behalf of the Adopting Employer or the Plan Administrator.

8.6 **Records and Reports.** The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

8.7 **Authorization of Benefit Payments.** The Plan Administrator (or the Claims Administrator as its designee) shall issue directions to the Trustee concerning all benefits which are to be paid from the Trust, pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.

8.8 **Other Powers and Duties of the Administrator**. The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) Discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility and to determine all questions arising in the administration and application of the Plan;

(b) To receive from the Adopting Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) To furnish the Adopting Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) To appoint individuals to assist in the administration of the Plan and any other agents the Plan Administrator deems advisable including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.

ARTICLE IX.
PLAN AMENDMENT AND TERMINATION

9.1 **Amendment by Adopting Employer.** The Adopting Employer reserves the right to amend, alter, or wholly revise this Plan or the Adoption Agreement, prospectively or retrospectively, at any time by the action of its Managing Body, and the interest of each Participant is subject to the powers so reserved. The Adopting Employer expressly may amend, alter or wholly revise this Plan or the Adoption Agreement if it determines it necessary or desirable, with or without retroactive effect, to comply with the law. Such changes shall not affect any right to benefits that accrued prior to such amendments. Such amendment shall be made in writing and shall be delivered promptly to the Claims Administrator, Plan Administrator, and Trustee.

9.2 **Adopting Employer's Right to Terminate.** Although the Adopting Employer expects the Plan to be maintained for an indefinite time, the Adopting Employer reserves the right to terminate the Plan or any portion of the Plan at any time. Such termination shall not affect any right to benefits that accrued prior to such termination. Such action shall be made in writing and shall be delivered to the Claims Administrator, Plan Administrator, and Trustee at least ninety (90) days prior to the effective date of the termination.

ARTICLE X.
GENERAL PROVISIONS

10.1 **No Reversion to the Plan Administrator or Adopting Employer**. Except as specifically allowed under the Trust, no part of the corpus or income of the Trust shall revert to the Adopting Employer or be used for or diverted to, purposes other than the exclusive benefit of participants and other persons entitled to benefits under the Plan.

10.2 **Persons Dealing With Trust**. No person dealing with the Trust shall be required to see to the application of any money paid or property delivered to the Trust, or to determine whether or not the Trust is acting pursuant to any authority granted to them under the Trust.

10.3 **Non-Alienation of Benefits**. Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Adopting Employer, Plan Administrator and/or Claims Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

10.4 **Action by Employer**. Whenever the Adopting Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the Managing Body of the Adopting Employer or such representatives of the Adopting Employer as the Managing Body may designate.

10.5 **No Guarantee of Tax Consequences**. Notwithstanding any provision in this Plan to the contrary, this Plan makes no commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not so excludable.

10.6 **Compensation and Expenses**. The cost of administering the Plan and Trust shall be paid as described in the Adoption Agreement.

10.7 **Governing Law**. This Plan shall be construed and enforced according to the laws of the State identified in the Adoption Agreement, except to the extent preempted by federal law.

10.8 **Family and Medical Leave Act of 1993 ("FMLA")**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with FMLA, to the extent the Adopting Employer is subject to such law.

10.9 **Newborns' and Mothers' Health Protection Act ("NMHPA").** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA. Federal law requires the following statement be included in the Plan document, verbatim:

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the

attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on pre-certification, contact your Plan Administrator.

10.10 **Women's Health and Cancer Rights Act of 1998 ("WHCRA").** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with WHCRA.

10.11 **Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with COBRA. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA and such policies shall be incorporated herein by reference.

10.12 **Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with USERRA. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA and such policies shall be incorporated herein by reference.

10.13 **Plan Not a Contract of Employment**. The Plan is not an employment agreement and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Adopting Employer's right to discharge an Employee at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

10.14 **Erroneous Payments.** If the Plan makes a payment for benefits in excess of the benefits required by the Plan or makes a payment to or on behalf of an individual who is not currently covered by the Plan, the Plan shall be entitled to recover such erroneous payment from the recipient thereof.

10.15 **Medicare Secondary Payer.** The Plan shall comply with the Medicare secondary payer rules found in 42 U.S.C. § 1395y. In general, the Plan shall pay benefits primary to Medicare if any one of the following conditions is satisfied: (a) the Adopting Employer employed twenty (20) or more employees for each working day in at least twenty (20) weeks in either the calendar year in which the claim is made or the preceding calendar year, the Participant is employed by the Employer, and the Participant is actually covered by Medicare by reason of obtaining the age of 65; (b) the Adopting Employer employed 100 or more employees on at least 50% of its regular business days during the calendar year preceding the year in which the claim was made, the Participant is employed by the Employer, and the Participant is actually covered by Medicare by reason of disability; and (c) the Participant is entitled to Medicare by reason of end stage renal disease and the claim is made during the thirty (30) month period beginning in the first month in which such Participant is entitled to benefits under Medicare (regardless of whether he/she applies for such benefits). In all other cases, the Plan shall pay benefits secondary to Medicare.

10.16 **Medicare Part D.** The Plan shall cooperate with Medicare Part D prescription drug plans (and Covered Individuals who are enrolled in such plans) with respect to coordination of benefits between the Plan and the Medicare Part D plan, including the provision of information to the

Medicare Part D plan (or the Covered Individuals) regarding the benefits provided under the Plan for costs covered by the Medicare Part D plan. Covered Individuals enrolled in Medicare Part D plans shall cooperate with the Plan so that the Plan may perform its obligations under this subsection.

10.17 **Exhaustion of Administrative Remedies; Statute of Limitations.** For all claims subject to the administrative procedures described in Article VI, exhaustion of those administrative procedures is required prior to the initiation of a legal action. Thereafter, unless specifically provided otherwise in the Adoption Agreement, legal action by a Participant, or someone on behalf of a Participant, must be initiated within one (1) year of receipt of the written notification of denial upon appeal. To the extent exhaustion of the appeal process is not required, a Participant, or someone on behalf of the Participant, must initiate legal action within one (1) year of having submitted the initial claim request to the Plan Administrator, or its designee. No legal action may be brought by a Participant, or someone on behalf of the Participant, after expiration of the applicable limitations period. This Section 10.17 shall apply to the extent the provisions hereof are not prohibited by applicable law.

10.18 **Michelle's Law.** Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner as required by Michelle's Law.

10.19 **Health Care Reform.** The Plan is intended to be exempt from the provisions of the Patient Protection and Affordable Health Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act ("Reconciliation Act"), to the fullest extent allowed by law. The Plan may be exempt from one or more provisions of PPACA for the following reasons:

(a) If provided in the Adoption Agreement, the Plan is intended to be a grandfathered plan within the meaning of section 1251 of PPACA.

(b) If, to be eligible to receive contributions under the Plan, a Participant must be covered under an employer-sponsored group medical plan (whether sponsored by the Employer or another employer), then the Plan is intended to be an integrated HRA as defined under applicable regulatory guidance.

(c) If provided in the Adoption Agreement, the Plan is intended to be an excepted benefit under the HIPAA portability rules.

For purposes of the foregoing, to the extent necessary to ensure the Plan is either an integrated HRA or an excepted benefit under HIPAA, the Plan described in this document shall be disaggregated into separate plans each of which will be either an integrated HRA or an excepted benefit under HIPAA. In the event such disaggregation is necessary, each disaggregated plan shall be treated and operated as a separate plan for all purposes.