City of South San Francisco

Health Reimbursement Arrangement (HRA)
Plan Document

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Aviben

Benefits Administrator. Elevated Solutions.

Retirement Health Savings Plan ("HRA")
Plan Document

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ARTICLE I
INTRODUCTION

Sec. 1.1 **Establishment and Governing Documents.** The executed Adoption Agreement and this Plan Document (v.12.02.16), including applicable Addenda, constitute the "Plan" for an Adopting Employer. The Effective Date of the Plan is set forth in the Adoption Agreement.

Sec. 1.2 **Purpose.** The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for certain Health Care Expenses as provided in this Plan. It is the intention of the Adopting Employer that the benefits payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Code §§ 105(b) and 106. 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, IRS Notice 2002-45, IRS Notice 2013-54, IRS Notice 2015-87 and Final Regulations jointly issued on November 18, 2015 by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration) and the Department of health and Human Services, (i.e., Final Rules for Grandfathered Plan, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act.)

Sec. 1.3 **Governing Law and Rules of Construction.** This Plan is intended to be in full compliance with applicable requirements of the Internal Revenue Code of 1986 (the "Code") as amended from time to time. Notwithstanding anything in this Plan to the contrary, this Plan is intended to be in full compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") only if so designated in the Adoption Agreement. The Plan shall be administered and construed consistent with said intent.

Sec. 1.4 **ACA Compliance.** This Plan document is intended to constitute good faith compliance with respect to the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act or "ACA"), and the Plan shall be interpreted and applied in a manner that is consistent with the statutes, regulations and applicable guidance issued thereunder. In the absence of explicit regulatory guidance, the Plan will be applied and interpreted in a manner that is consistent with a good faith interpretation of the legal requirements of ACA. The Plan shall only be deemed to be a "grandfathered plan" under ACA rules if such designation has been made in writing by the Adopting Employer, specified in the Adoption Agreement, and other ACA requirements for grandfathered plans are satisfied.

Sec. 1.5 **Compliant Plan Models**. Effective for Plan Years beginning on or after January 1, 2017, in order to comply with related legislation and regulatory guidance the Affordable Care Act ("ACA"), (which generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits), an HRA must fit into one of these compliant designs specified in the Adoption Agreement effective for Plan Years beginning on or after January 1, 2017:

(a) Integrated HRA as described in regulatory guidance issued by the Federal government, specifically:

(1) FAQs About the Affordable Care Act Implementation (Part XI), on January 24, 2013; and

(2) IRS Notice 2013-54, and IRS Notice 2015-87 issued by the Department of Treasury, and related guidance issued by the Federal government relating to the Application of

Reform and other provisions of the Affordable Care Act to HRAs, Health FSAs and certain other employer healthcare arrangements; and

(3) Final Regulations jointly issued by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration), and the Department of Health and Human Services on November 18, 2015, (i.e., Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescission, Dependent Coverage Appeals, and Patient Protections Under the Affordable Care Act.)

(b) A Retiree-Only HRA as described in the same guidance listed above that has fewer than two active employees participating in the Plan on the first day of the Plan Year.

(c) A restricted HRA that is limited to the reimbursement of vision and/or dental premiums and/or out-of-pocket expenses.

(d) A "frozen" HRA that does not meet one of the three design criteria above and which no longer receives any contributions into the HRA. Although the HRA has been frozen, the amounts that have been contributed to the HRA Plan on a participant's behalf during Plan Years beginning before January 1, 2014, will continue to be available to that participant after December 31, 2013, to reimburse the Participant's eligible expenses under the terms of the HRA.

2013-2014 Transition Rule For Pre-2014 Amounts. Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

ARTICLE II
DEFINITIONS

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

Sec. 2.1 **Adopting Employer.** "Adopting Employer" means the entity that adopts this Plan by completing and executing an Adoption Agreement, which may include a joint powers agreement.

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

Sec. 2.3 **Authorized Representative.** "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 effect signed by the claimant and notarized must be received by the Plan. An assignment for purposes of payment is not a designation of an "Authorized Representative." For other matters, including but not limited to verifying the HC Account status, the Participant may notify the Plan orally or by other reasonable means to authorize a person to act on the Participant's behalf.

Sec 2.4 **Claims Administrator.** "Claims Administrator" means, unless specifically noted otherwise in the Adoption Agreement, EBC. If for any reason there is no entity so identified or the contractual relationship ends, the Adopting Employer shall act as the Claims Administrator.

Sec. 2.5 **COBRA.** "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as set forth in Code section 4980B.

Sec. 2.6 **Code.** "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Sec. 2.7 **Covered Individual.** "Covered Individual" means a Participant, Dependent of a Participant (including the Spouse of a Participant), and any other person appropriately covered under the Plan. Notwithstanding the foregoing, effective January 1, 2017 a "Covered Individual" in an Integrated HRA is limited to Participant and his or her Dependents who (i) are enrolled in the Adopting employer's group health plan, or (ii) one or more of the Participant's Dependents that are actually enrolled in a group health plan sponsored by a different employer that is HRA compatible (i.e., the other group health plan does not consist solely of excepted benefits) and can be integrated with an HRA Plan). By way of clarification, individual coverage is not a compliant design.

Sec. 2.8 **Dependent.** "Dependent" means, unless specifically otherwise specified in the Adoption Agreement, a person who is a dependent within the meaning of Code § 152 as modified by Code § 105(b), and any child (as defined in Code § 152(f)(1)) of the Participant may be covered through his or her 26th birthday (although the Plan Administrator may extend coverage through the end of the calendar year in which the child attains age 26 as provided in the Adoption Agreement).

Sec. 2.9 **EBC** "EBC" means Educators Benefit Consultants, LLC.

Sec. 2.10 **Employee.** "Employee" means any person employed by the Adopting Employer on or after the Effective Date, except that it shall not include a self-employed individual as described in

Code § 401(c). All employees who are treated as employed by a single employer under Subsections (b), (c) or (m) of Code § 414 are treated as employed by a single employer for purposes of this Plan.

Employee does not include the following:

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

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

(c) Any employee who is a leased employee as defined in Code § 414(n)(2).

Sec. 2.11 **Employer Contribution.** "Employer Contribution" means a nonelective contribution made by the Adopting Employer on behalf of each Participant in the Plan. 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.

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

Sec. 2.13 **ERISA.** "ERISA" means the Employee Retirement Income Security Act of 1974 and regulations thereunder, as amended from time to time. Whether this Plan is subject to ERISA is set forth in the Adoption Agreement. Notwithstanding the forgoing, Plans sponsored by public sector entities are not subject to ERISA.

Sec. 2.14 **HC Account.** "HC Account" means "health care account" and is the record keeping account established by the Plan for each Participant.

Sec. 2.15 **Health Care Expense.** "Health Care Expense" means, unless otherwise specifically noted in the Adoption Agreement, an expense incurred by a Covered Individual for medical care to the maximum extent permitted by law, but only to the extent that the Covered Individual incurring the expense is not reimbursed for the expense through another source, including other insurance or other accident or health plan.

Notwithstanding the foregoing:

(a) If the Adopting Employer sponsors a Code § 125 plan (or "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.

(b) A Health Care Expense shall include medical care as defined in Code § 213(d) as modified to the extent required by law. 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 Code § 213(d)(10).

(c) A Health Care Expense is incurred at the time the medical care or service which gave rise to the expense is furnished.

(d) **Note**: Consistent with applicable regulatory guidance, including IRS Notice 2013-54, and IRS 2015-87 reimbursement for certain HRAs differ, depending on whether the Adopting Employer's group health plan that is integrated with the integrated HRA meets ACA's minimum value standards. Also, any integrated HRA as well as any Retiree-Only HRA must allow eligible employees or retirees, as applicable, waive participation at least once each Plan year and at termination of employment as provided in Sec. 4.5(e).

(1) Integrated group health plan that provides ACA-specified minimum value. If an Adopting Employer's group health plan (and, if applicable, a Participant's Dependent's employer-sponsored group health plan) provides ACA-specified minimum value, then the integrated HRA may pay for that group health plan's premiums and reimburse any type of qualified medical expense – including an ACA-specified essential health benefit excluded under the ACA-specified minimum value group health plan.

Example: An employer offers an ACA-specified minimum value group health plan that excludes pediatric dental and vision (an ACA-specified essential health benefit), along with an integrated HRA with a $3,000 annual contribution limit that meets the integration requirements under applicable regulatory guidance. The integrated HRA can reimburse participants' pediatric dental and vision expenses.

(2) Integrated group health plan that does not provide ACA-specified minimum value. If an Adopting Employer's group health plan (and, if applicable, a Participant's Dependent's employer-sponsored group health plan) does not provide minimum value (and is not limited to ACA-specified excepted benefits), then the integrated HRA may reimburse co-pays, coinsurance, deductibles and premiums for non-HRA coverage, along with other qualified medical expenses – but not any medical expenses for ACA-specified essential health benefits. Expense reimbursements permitted under this type of Integrated HRA must be carefully reviewed to ensure compliance.

Example: An employer offers a group health plan that does not provide ACA-specified minimum value, along with an integrated HRA with a $500 annual contribution limit that meets the integration requirements under applicable regulatory guidance. The integrated HRA is not permitted to reimburse expenses for any essential health benefits – e.g., prescription drugs, lab costs or pediatric dental and vision – but can reimburse co-pays, deductibles, premiums for non-HRA coverage and other qualified medical expenses.

(3) Defined terms for this provision:

(i) ACA-specified minimum value: ACA-specified minimum value is defined as the minimum threshold for the value of a health plan under ACA rules. A plan with minimum value should cover, on average, at least 60 percent of the cost of all benefits. Regulatory guidance under ACA provides methods to make the determination of whether the minimum value threshold is satisfied.

(ii) ACA-specified essential health benefits: Generally, ACA provides that essential health benefits must include items and services within at least the following 10 categories:

a. Ambulatory patient services;

b. Emergency services;
c. Hospitalization;
d. Maternity and newborn care;
e. Mental health and substance use disorder benefits, including behavioral health treatment;
f. Prescription drugs;
g. Rehabilitative and habilitative services and devices;
h. Laboratory services;
i. Preventive and wellness services and chronic disease management; and
j. Pediatric services, including oral and vision care.

The Department of Health and Human Services ("HHS") is responsible under ACA to further define the scope of essential health benefits. Applicable regulatory guidance under ACA provides information about when and how determinations relating to ACA-specified essential health benefits are to be made.

(e) In accordance with Sec 2.7 of the Plan and IRS Notice 2015-87, only Health Care Expenses of Covered Individuals are reimbursable under this Plan. Effective January 1, 2017 "Covered Individuals" for Integrated HRA only include the Participant and his or her Spouse or other Dependents that are enrolled in the Adopting Employer's group health plan that is integrated with this HRA Plan, or Dependents who are enrolled in a different employer's group health plan that is HRA compatible because it provides minimum essential coverage as defined under the ACA. This subsection (e) shall be applied in accordance with the following rules:

(1) The Adopting Employer sponsoring must offer a group health plan (other than this HRA) that does not consist solely of excepted benefits (an "HRA compatible group health plan").

(2) Employees and their Dependents receiving the HRA must actually be enrolled in the Adopting Employer's HRA compatible group health plan.

(3) Dependents must actually be enrolled in the Adopting Employer's HRA compatible group health plan, or another HRA compatible group health plan that does not consist solely of excepted benefits.

(4) If one or more of the Participant's Dependents is not enrolled in the Adopting Employer's HRA compatible group health plan, the Dependent must attest that he or she is actually enrolled in another employer's HRA compatible group health plan. The attestation must be in a form that is approved by the Claims Administrator.

Sec. 2.16 **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder, as amended from time to time.

Sec. 2.17 **Health Reimbursement Arrangement ("HRA").** "Health Reimbursement Arrangement" ("HRA") means an 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).

Sec. 2.18 **Highly Compensated Individual.** "Highly Compensated Individual" means an individual who is:

(a) one of the five (5) highest paid officers;

(b) a shareholder who owns more than 10 percent in value of the stock of the employer; or

(c) among the highest paid twenty-five percent (25%) of all Employees.

Notwithstanding the foregoing, "Highly Compensated Individuals do not include: (1) Employees who have not completed 3 years of service; (2) Employees who have not attained age twenty-five (25); (3) part-time or seasonal Employees; (4) Employees not included in the Plan who are included under a collective bargaining agreement; and (5) Employees who are nonresident aliens and who receive no earned income from a source within the United States.

Sec. 2.19 **Managing Body.** "Managing Body" means the person or persons with authority to make decisions for the Adopting Employer.

Sec. 2.20 **Participant.** "Participant" means an Employee who has become, and has not ceased to be, a Participant pursuant to Article IV. In addition, Participant includes persons "deemed" to be Participants under specific provision of this Plan.

Sec. 2.21 **Plan.** "Plan" means the Adopting Employer's plan as may be amended from time to time. It consists of a completed Adoption Agreement, the Plan Document (v.07.09.13), and applicable Addenda. The Plan name and Plan number are set forth in the Adoption Agreement.

Sec. 2.22 **Plan Administrator.** "Plan Administrator" means the entity, person or persons responsible for the Plan's administration as determined under Section 9.1.

Sec. 2.23 **Plan Sponsor.** "Plan Sponsor" means the Adopting Employer.

Sec. 2.24 **Plan Year.** "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.

Sec. 2.25 **Spouse.** "Spouse" means, unless otherwise specifically defined in the Adoption Agreement, an individual who is legally married to a Participant (and who is treated as a spouse as recognized to be legally married under the Code).

ARTICLE III
ADOPTING EMPLOYER

Sec. 3.1 **Adoption of Plan.** An eligible employer may adopt the Plan by resolution duly adopted by its Managing Body, as represented and warranted in the Adoption Agreement, and upon execution of an Adoption Agreement.

Sec. 3.2 **Cessation of Employer Adoption.** An Adopting Employer may cease to be an Adopting Employer in accordance with Articles IX and X.

Sec. 3.3 **Recordkeeping and Reporting.** An Adopting Employer shall furnish, or arrange for the furnishing, to the Claims Administrator the information with respect to each Covered Individual necessary to enable the Claims Administrator to maintain records sufficient to determine the benefits due to or which may become due and to prepare and provide any reports required by law.

ARTICLE IV
ELIGIBILITY AND PARTICIPATION

Sec. 4.1 **Eligibility.** Each Employee shall be eligible to participate in this Plan upon meeting the eligibility requirements set forth in the Adoption Agreement.

Sec. 4.2 **Participant Status.** An Employee who has met the eligibility requirements described in Section 4.1 shall be a Participant as of the Employee's Entry Date.

Sec. 4.3 **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 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 do so relieves the Plan, Plan Administrator, Claims Administrator and Sponsor of any obligations under this Plan with respect to that Participant and any others claiming entitlement to benefits under this Plan through that Participant.

Sec. 4.4 **Termination of Contributions.** A Participant shall cease to be eligible to receive contributions under this Plan at midnight of the following dates:

(a) Except as otherwise provided in the Adoption Agreement (in particular, with respect to certain contributions for unused sick and vacation payments while a Participant and actively employed by the Adopting Employer), the date of the death of the Participant;

(b) Except as otherwise provided in the Adoption Agreement (in particular, with respect to certain contributions for unused sick and vacation payments while a Participant and actively employed by the Adopting Employer), 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 4.1, as may be amended from time to time in accordance with Article X; or

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

(e) The date, if any, that a Participant elects to opt out of Plan Participation pursuant to Sec. 4.5(e) of the Plan.

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

Sec. 4.5 **Termination of Participation.** A Participant automatically ceases to be a Participant (i.e., access to the HC Account terminates) at midnight of the earliest of the following dates:

(a) Except as otherwise provided in the Adoption Agreement, the date of the death of the Participant;

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

(c) Except as otherwise provided in the Adoption Agreement (in particular, with respect to retiree-only plans and permitted spend down reimbursements after termination), the date of the termination of the Participant's employment with the Adopting Employer; or

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

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

(e) Effective January 1, 2017 a Participant may opt out of participation in the Plan and waive future reimbursements from the Plan, subject to the following:

(1) The Participant must be given the right to opt out of Plan participation at least once each Plan Year and also upon termination of employment.

(2) The Participant's election to opt out of Plan participation and HRA ~~rembursements~~reimbursements must be irrevocable and must be either:

(A) Permanent, or
(B) Reinstatable upon one of the following events:
(i) A fixed date or event
(ii) The participant's death, or
(iii) The earlier of (i) or (ii) above.

For example, participants or former participants who have opted out of the Plan can reinstate their HC Account balance when they become eligible for Medicare. The HC Account balance can also be used by eligible family members if the HC Account balance is reinstated upon the Participant's death.

(3) After the opt out election becomes effective, the Participant, former Participant, or eligible family member cannot have access to the balance in his or her HC Account prior to reinstatement. In that regard, any claims incurred after the waiver and prior to the reinstatement are not eligible for reimbursement.

Sec. 4.6 **Deemed Participants.** For certain purposes, persons that were not Employees are deemed to be Participants as required by law.

ARTICLE V
PLAN BENEFITS

Sec. 5.1 **HC Account.** The HC Account will be credited with the Employer Contributions. A Participant's HC Account will be decreased from time to time in the amount of payments made to the Participant for Health Care Expenses.

Sec. 5.2 **Claims for Reimbursement.**

(a) Claims for reimbursement under this Plan shall be made by completing a claim form and submitting such form to the Claims Administrator of this Plan. The Claims Administrator is entitled to rely on the information provided on the claim form in processing claims under this Plan.

(b) Unless otherwise specifically noted in the Adoption Agreement, a claim is reimbursable as soon as administratively feasible after it is submitted for payment. Where circumstances beyond the Participant's control prevent submission within a time frame established in the Adoption Agreement, 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 VII.

Sec. 5.3 **Incurred Expenses.** To be reimbursable, the Participant must have incurred a Health Care Expense after his/her Entry Date. An expense is "incurred" when the Participant is provided with the care giving rise to the Health Care Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.

Sec. 5.4 **Timing of Reimbursement.** Unless specifically provided otherwise in the Adoption Agreement, a Participant shall be reimbursed at least:

(a) once per month, or

(b) when the total reimbursement for Health Care Expenses first equals or exceeds $50.00.

Sec. 5.5 **Maximum Reimbursement.** Unless specifically provided otherwise in the Adoption Agreement, 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. Except as limited by the preceding sentence, there is no maximum reimbursement amount a Participant may receive during a Plan Year. The maximum reimbursement requirements apply to the Participant, Spouse, and Dependents on an aggregate basis, not an individual basis. If a Participant's claim is for an amount that is more than the Participant's current HC Account balance, the excess, unreimbursed part of the claim will be carried into the subsequent month(s), to be 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 carried over into the subsequent month(s) if: (a) the claim has been pending at least eighteen (18) months; or (b) no further Employer Contributions will be made to the Participant's HC Account under Article VI.

Sec. 5.6 **Participant's Death.** In the event a Participant dies having incurred a Health Care Expense which would have been reimbursable out of the Participant's HC Account had the Participant not died and a person or the Participant's estate has paid for or assumed liability for the expense, reimbursement

may be made to that person or the estate for that payment or assumption for up to one year after Participant's death.

See Section 13.3, clause (b) for further information regarding access to HC Account by legal spouse and legal dependent(s) due to Participant's death.

Sec. 5.7 **Nondiscrimination.** This Plan is intended to be nondiscriminatory and to meet the requirements under applicable sections of the Code. If the Plan Administrator 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 shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitation. Such action may include recharacterizing the HC Account or HC Accounts as "restricted" to insurance premium reimbursement.

Sec. 5.8 **HC Account Forfeitures.** Unless specifically provided otherwise in the Adoption Agreement, any amount remaining in a Participant's HC Account shall be forfeited following the later to occur of:

(a) The termination of Participant's participation in the Plan;

(b) The termination of any continuation coverage provided by the Plan under applicable law; or

(c) The termination of any coverage provided by the Plan in lieu of continuation coverage required by applicable law (i.e., spend down feature referenced in Section 13.3 of this Plan Document).

(d) Notwithstanding the foregoing, a Participant's HC Account shall not be forfeited during the period in which a Participant has elected, pursuant to Sec. 4.5(e) of the Plan, to "opt out" of Plan Participation but has elected reinstatement upon (i) a fixed date or event, (ii) death or (iii) the earlier of (i) or (ii).

The Plan Administrator may use such forfeited amounts to defray the reasonable administrative costs of the Plan or for any other purpose permitted by law. Any amounts remaining after payment of fees will be divided among participants eligible to receive an allocation of the forfeitures on a per capita basis.

Sec. 5.9 **Coordination with Cafeteria Plan.** To the extent the Adopting Employer also sponsors a cafeteria plan within the meaning of Code § 125, and a Covered Individual incurs expenses eligible for reimbursement under both programs, unless specifically provided otherwise in the Adoption Agreement, the cafeteria plan will pay first. However, the choice cannot be left to the Participant.

Sec. 5.10 **Coordination with an HSA.** If a Participant is covered by a high deductible health plan that makes the Participant eligible to establish a health savings account ("HSA"), under Internal Revenue Code § 223, an HSA eligibility rule applies to such Participant. If the Participant is eligible to be reimbursed by an HRA, the Participant will lose eligibility to deposit funds into his or her HSA. If the Participant wishes to fund his or her HSA, the Participant must suspend reimbursements from his or her HRA using the Plan Administrator's "suspension form". A Participant will suspend his or her HRA reimbursements for a twelve month period for as many twelve month time periods that Participant wishes to fund his or her HSA. In lieu of suspending HRA reimbursements (and as permitted by the Employer), a

Participant may elect to have his or her HRA reimbursements restricted to vision and dental expenses only. An affected Participant should contact the Plan Administrator regarding this coordination rule to receive a further explanation and the appropriate form. This provision shall be administered consistent with applicable regulatory guidance.

Sec. 5.11 **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 Code § 129 shall not be reimbursed under this Plan.

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

ARTICLE VI
EMPLOYER CONTRIBUTIONS

Sec. 6.1 **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 year to year as announced by the Adopting Employer prior to the Plan Year start and reflected in the Adoption Agreement. As applicable (where a Trust is adopted), and unless specifically provided otherwise in the Adoption Agreement, the Employer Contribution shall be available for reimbursement as soon as administratively feasible following its receipt by the Trustee and placed in the Trust.

Sec. 6.2 **No Employee Contributions.**

(a) Generally, no contributions other than Employer Contributions are required nor will they be accepted.

(b) Notwithstanding subsection (a), the following contributions other than Employer Contributions may be permitted in specific circumstance set forth in the Adoption Agreement and pre-approved by EBC:

(1) Contributions required for COBRA continuation coverage, as described in Article XIII; and

(2) Employee contributions mandated by a collective bargaining agreement (including, as applicable, unused vacation or sick leave).

Sec. 6.3 **Funding.** All Employer Contributions shall be held as provided in the Funding Addendum of the Plan, signed by the Adopting Employer and, if applicable, the Trustee.

ARTICLE VII
PREPAID BENEFITS CARD

Sec. 7.1 **Use of Prepaid Benefits Card.** Participants may, subject to the Adoption Agreement election and procedures established by the Adopting Employer and applied in a uniform, nondiscriminatory manner, use "Prepaid Benefits Cards" (hereinafter, the "Cards") to reimburse Health Care Expenses under the Plan. If so elected in the Adoption Agreement, these procedures are contained in the Prepaid Benefits Card Addendum to the Plan.

Sec. 7.2 **Participant Certification.** Each Participant issued a Card shall certify upon issuance and each plan year thereafter that the card shall only be used for Health Care Expenses. The Participant shall also certify that any expense paid with the Card has not already been reimbursed by any other plan or source, and that the Participant will not seek reimbursement under any other plan covering health benefits.

Sec. 7.3 **Insurance and Card Revocation.** Such Card shall be issued upon the Participant's commencement of participation and reissued (or remain active) for coverage periods during which the Participant remains a Participant in the Plan. Such Card shall be automatically cancelled if the Participant dies, terminates employment or otherwise ceases to be an eligible Employee for any reason.

Sec. 7.4 **Maximum Health Care Expenses Payable with the Card.** The maximum dollar amount of Health Care Expenses payable with the Card shall be the maximum dollar amount of coverage available in the Participant's HC Account, unless otherwise provided in the Adoption Agreement. The Cards shall only be used for the purchase of Health Care Expenses eligible for reimbursement under the Plan.

Sec. 7.5 **Only Approved Merchants.** The Cards shall be ineffective (i.e., rejected) except at those merchants and service providers authorized by the Adopting Employer. The Employer's authorization of merchants and service providers shall comply with IRS guidance governing the use of Cards, including Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2, and such superseding or additional guidance as may be promulgated by the IRS.

Sec. 7.6 **Substantiation of Health Care Expenses.** All purchases with the Cards must be substantiated and may be substantiated in any manner allowed by applicable IRS guidance. The Prepaid Benefits Card Addendum provides the substantiation methods used by EBC and is updated from time-to time. Without limiting the generality of the preceding sentences, the following rules apply:

(a) General Rule: Except as otherwise allowed by IRS guidance, substantiation will be made by submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount.

(b) Co-Payment Match Substantiation Method: To the extent permitted by IRS guidance, charges shall be considered substantiated if they satisfy the "co-payment match substantiated method" as set forth in Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2 and superseding or additional IRS guidance. Under that method, a charge is considered substantiated without the need for submission of a receipt or further review if the Adopting Employer's group health plan has co-payments in specific dollar amounts, and the dollar amount of the transaction at a health care provider (as identified by its merchant category code), or other merchant/service provider as otherwise allowed by IRS guidance, equals an exact multiple of not more than five times the dollar amount of the co-payment for the

specific service (i.e., pharmacy benefit co-payment, co-payment for a physician's office visit, etc.) under the Adopting Employer's group health plan covering the specific Participant. In addition, if a health plan has multiple co-payments for the same benefit (e.g., tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will similarly be fully substantiated without the need for submission of a receipt or further review.

(c) Recurring Expenses: To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if they match expenses previously approved as to amount, provider and time period (e.g., for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount).

(d) Real Time Substantiation: To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if the merchant, service provider, or other independent third party (e.g., pharmacy benefit manager), at the time and at the point of sale, provides information to verify to EBC (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for an eligible Health Care Expense.

(e) Inventory Information Approval System: Charges shall be considered substantiated without the need for submission of a receipt or further review if they are made through an "inventory information approval system" as set forth in Section III.B of Notice 2006-69 and additional or superseding IRS guidance.

(f) Direct Third-Party Substantiation: Charges shall be considered substantiated without the need for submission of a receipt or further review by submission of information from an independent third party (such as an "Explanation of Benefits" from an insurance company) indicating the date of the service or product and the Participant's responsibility for payment (e.g., co-insurance payments and amounts below the plan's deductible).

Sec. 7.7 **Conditional Until Substantiated.** All charges on the Card shall be conditional pending substantiation. If a charge is later determined by EBC not to be an eligible Health Care Expense, EBC, in its discretion, shall use one or more of the following correction methods to make the Plan whole:

(a) Repayment of the improper amount by the Participant;

(b) Claims substitution or offset of future claims until the amount is repaid; and

(c) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law.

If those corrections prove unsuccessful or are otherwise not available, the Participant shall remain indebted to Adopting Employer for the amount of the improper payment. In that event and consistent with its business practices, the Adopting Employer will treat the payment as it would any other business indebtedness. Until the amount is repaid, EBC shall take further action to ensure that further violations of the terms of the Card do not occur, up to and including denial of access to the Card.

ARTICLE VIII
CLAIMS PROCEDURES

Unless otherwise specifically noted in the Adoption Agreement, the following procedures apply:

Sec. 8.1 **Initial Claim Determination.**

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

(b) Extension of Time. If the decision maker is not able to determine the claim within this time period due to matters beyond its control, the decision maker may take an additional period of up to fifteen (15) days to determine the claim.

(1) If this additional time will be needed, the decision maker 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.

(2) This extension is only available once.

(3) 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 decision maker's period of time to make a decision is "tolled."

(1) Tolling: The period of time in which the decision maker 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.

(2) Notification: For this purpose, notification can be made orally to the claimant or the health care professional, unless the claimant requests written notice.

(3) Timeframe: The notification will include a time frame in which the necessary information must be provided.

(4) Once the necessary information has been provided, the decision maker 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.

Sec. 8.2 **Decision.**

(a) Notification of Decision. Written (or electronic) notification of the decision maker's determination must be provided to the claimant or the claimant's Authorized Representative.

(1) Such notification must be provided only where the decision is adverse.

(2) "Adverse" means:

(i) A denial, reduction, or termination of, or

(ii) A failure to provide or make payment (in whole or in part) for a benefit.

(b) Adverse Decision. For adverse claim determinations, the notification shall reflect at least the following:

(1) state the specific reason(s) for determination;

(2) reference specific Plan provision(s) upon which the determination is based;

(3) describe additional material or information necessary to complete the claim and why such information is necessary;

(4) describe Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;

(5) 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); and

(6) where the decision involves scientific or clinical judgment, disclose either: (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge upon request.

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.

Sec. 8.3 **Access to Relevant Documents.**

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

(b) 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.

Sec. 8.4 **Appeal 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) Submission & Consideration of Comments. The claimant or the claimant's Authorized Representative will have the opportunity to submit documents, written comments, or other information in support of the appeal. 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.

(d) 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.

(e) 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 decision maker shall review of claim and make a determination no later than sixty (60) days from the date the review request was received.

(f) Decision. The review of the appeal 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 decision maker may rely upon protocols, guidelines, or other criterion.

(g) Notification of Decision. Written (or electronic) notification of the decision maker's determination must be provided to the claimant or the claimant's Authorized Representative.

(1) Such notification must be provided whether the decision is adverse or not adverse.

(2) "Adverse" means:

(i) A denial, reduction, or termination of, or

(ii) A failure to provide or make payment (in whole or in part) for a benefit.

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

(1) state the specific reason(s) for determination;

(2) reference specific Plan provision(s) upon which the determination is based;

(3) describe Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;

(4) 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);

(5) 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; and

(6) 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.

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.

(i) Not Adverse Decision. For appeal 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.

(j) External Appeal. To the extent applicable to the Plan under ACA, the claimant may request an external review of an adverse benefit determination from an independent review organization ("IRO") under rules specified by the Plan Administrator that are consistent with ACA requirements. Within four (4) months of receipt of the denial of the appeal by the Plan Administrator, the claimant must notify, in writing, the Plan Administrator of his or her intent to pursue an external review. If the claimant requests an external review, the IRO will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue an external review. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Sec. 8.5 **Alternative Rules, as Applicable.** Notwithstanding anything to the contrary herein if (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. § 54.9801-2 or the Plan is a grandfathered plan under ACA, claims procedures shall be established by the policies and procedures of the Plan Administrator and any other applicable law.

Sec. 8.6 **Additional ACA Rules, as Applicable.**

(a) Adverse Benefit Determination: An adverse benefit determination shall mean an "adverse decision" as described in Sec. 8.2(a)(2) and Sec. 8.4(g)(2), above, as well as any rescission of coverage as described in DOL Reg. § 2590.715-2712(a)(2).

(b) Full and Fair Review: A claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, at no charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements of DOL Reg. § 2590.715-2712(b)(2)(D).

(c) Notice. A description of internal and external claims processes and information about how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. § 2590.715-2719(b)(2)(ii)(E), as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically-appropriate manner as provided under DOL Reg. § 2590.715-2719(e) and the Plan must disclose contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHSA § 2793.

(d) Deemed Exhaustion of Internal Claims Process. If the Plan fails to strictly adhere to the claims and appeals requirements under ACA, as provided in DOL Reg. § 2590.715-2719(b)(2), the claimant may initiate an external review under Sec. 8.4(j) or may bring action under ERISA § 502(a).

ARTICLE IX
PLAN ADMINISTRATION

Sec. 9.1 **Plan Administrator.**

(a) The Plan Administrator shall be responsible for the general supervision of the Plan and therefore 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. If the Plan is subject to ERISA, the Plan Administrator shall also be the named fiduciary of the Plan in accordance with Section 402 of ERISA.

(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. Unless reflected in the Adoption Agreement otherwise, EBC is the Claims Administrator. When EBC is the Claims Administrator, EBC's role and responsibilities shall be determined consistent with this Plan and as specified under the terms of the written service agreement in effect between the Adopting Employer and EBC.

Sec. 9.2 **Agent for Service of Legal Process.** The agent for service of legal process for the Plan is the Plan Administrator.

Sec. 9.3 **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 another Employee of the Adopting Employer. Neither the Plan Administrator (including any designee), 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.

Sec. 9.4 **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 Plan Administrator.

Sec. 9.5 **Records and Reports.** The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

Sec. 9.6 **Authorization of Benefit Payments.** The Plan Administrator (or the Claims Administrator as its designee) shall authorize benefit payments and, to the extent applicable (where a Trust is adopted) 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.

Sec. 9.7 **Compensation and Expenses.** The Claims Administrator shall be entitled to reasonable fees for its services hereunder. Such fees and any expenses incurred by the Claims Administrator in connection with the Plan (including expenses and fees of persons hired or employed by them) shall be charged as specified in the Adoption Agreement.

Sec. 9.8 **Other Powers and Duties of the Plan 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 X
PLAN AMENDMENT AND TERMINATION

Sec. 10.1 **Plan Amendment by Adopting Employer.**

(a) The Adopting Employer reserves the right to amend, alter, or wholly revise this Plan Document, Adoption Agreement or any Addendum hereto, 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 Document, Adoption Agreement or any Addendum hereto 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 and Plan Administrator, and, as applicable, to the Trustee.

(b) Notwithstanding the above, where a Trust has been adopted, no amendment may be made that would increase substantially the duties or liabilities of the Trustee without its written consent or that would divert any part of the Trust assets to any use or purpose other than for the exclusive benefit of the Participants and other individuals entitled to benefits under the Plan; provided, however, that any such amendment may be made that may be or become necessary in order that the Trust will conform to all requirements of applicable federal and state laws.

Sec. 10.2 **Plan Termination by Adopting Employer.** Although the Adopting Employer expects the Plan to be maintained for an indefinite time, the Adopting Employer reserves the right to terminate the Plan and/or or any portion thereof at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Adopting Employer, the Plan shall terminate unless the Plan is continued by a successor to the Adopting Employer in accordance with the resolution of such successor's Managing Body. 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 promptly to the Claims Administrator and Plan Administrator and, as applicable, to the Trustee.

ARTICLE XI
GENERAL PROVISIONS

Sec. 11.1 **Reversion Rules.**

(a) Plan Funded Using a VEBA Trust:

(i) If the Plan is funded using a VEBA trust as provided in the Adoption Agreement and applicable Funding Addendum, no part of the corpus or income of the VEBA trust shall revert to an 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. Should the VEBA trust terminate, any assets remaining shall be used for a purpose consistent with the Plan and as permitted by law. A "VEBA trust" means a trust intended to qualify as a voluntary employees' beneficiary association under Section 501(c)(9) of the Code.

(ii) Exception: Notwithstanding subsection (i) above, if the Adopting Employer is specified as a tax-exempt organization in the Adoption Agreement, upon termination of the VEBA trust, any assets remaining may be reverted to an Adopting Employer after satisfaction of all remaining liabilities to VEBA trust beneficiaries.

(b) Plan Funded Using Section 115 Trust: If the Plan is funded using a Section 115 trust as provided in the Adoption Agreement and applicable Funding Addendum, upon termination of the Section 115 trust, any assets remaining may be reverted to an Adopting Employer after satisfaction of all remaining liabilities to Section 115 trust beneficiaries. A "Section 115 trust" means a trust intended to qualify as an integral part trust under Section 115 of the Code. The Adopting Employer of a Section 115 trust must be a state, a political subdivision of a state or an agency or instrumentality of a state, the income of which is excludible under Section 115 of the Code.

(c) Plan Funded using Adopting Employer Assets: If Plan benefits are paid from the Adopting Employer's general assets as provided in the Adoption Agreement and applicable Funding Addendum, nothing herein shall be construed to require the Adopting Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Adopting Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid.

Sec. 11.2 **Persons Dealing with the Trust.** If the Plan is funded using a VEBA trust or a Section 115 trust as provided in the Adoption Agreement and applicable Funding Addendum, no person dealing with the trust shall be required to see to the application of any money paid or property delivered to the trustee, or to determine whether or not the trust is acting pursuant to any authority granted to them under the Plan Document.

Sec. 11.3 **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, Claims Administrator and, as applicable, Trustee 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.

Sec. 11.4 **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. Participants involved in a divorce or child custody matter should be directed to have their legal counsel contact the Claims Administrator.

Sec. 11.5 **Action by Adopting 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.

Sec. 11.6 **Indemnification of Trustees.** If the Plan is funded using a VEBA trust or a Section 115 trust as provided in the Adoption Agreement and applicable Funding Addendum, unless prohibited or specifically required otherwise by applicable law, the Adopting Employer hereby agrees to indemnify the Trustee for and to hold it harmless against any and all liabilities, losses, costs or expenses (including legal fees and expenses) of whatsoever kind and nature which may be imposed on, incurred by or asserted against the Trustee at any time by reason of the Trustee's service under this Plan Document provided that the Trustee did not act dishonestly or in willful or negligent violation of the law or any applicable regulation under which such liability, loss, cost or expense arose.

Sec. 11.7 **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.

Sec. 11.8 **Governing Law.** Unless otherwise specified in the Adoption Agreement, this Plan shall be construed and enforced according to the laws of the state in which the Adopting Employer is legally organized except to the extent preempted by federal law.

Sec. 11.9 **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.

Sec. 11.10 **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 out-of-pocket costs, a Participant may be required to obtain precertification. For information on pre-certification, contact the Plan Administrator.

Sec. 11.11 **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.

Sec. 11.12 **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, and the Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA. In the absence of explicit regulatory guidance, the Plan will be applied and interpreted in a manner that is consistent with a good faith interpretation of the legal requirements of USERRA.

Sec. 11.13 **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 or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

Sec. 11.14 **Medicare Secondary Payer.** The Plan shall comply with the Medicare secondary payer rules found in 42 U.S.C. § 1395y. The Plan shall pay benefits primary to Medicare if:

(a) the Participant is employed by the Adopting Employer and is actually covered by Medicare by reason of obtaining the age of 65;

(b) at the time the claim is made the Adopting Employer employs 100 or more employees, the Participant is employed by the Adopting 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 twelve (12) 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.

Sec. 11.15 **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.

Sec. 11.16 **Certificates of Creditable Coverage.** To the extent required under COBRA, when coverage terminates, or upon request by a Covered Individual during coverage or within two (2) years of termination of coverage under this Plan, Covered Individuals will be provided with a certification of

creditable coverage by the Plan Administrator (or its designee). A request for a certification of creditable coverage should be directed to the Plan Administrator. Upon request, the Plan Administrator (or its designee) will issue the certification of creditable coverage as soon as reasonably possible.

Note: *Effective December 31, 2014, as applied pursuant to regulatory guidance, certificates of creditable coverage are no longer required to be provided to Covered Individuals.*

Sec. 11.17 **Inability to Locate Payee.** If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable and diligent efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due (a reasonable time shall be deemed to have passed after a claim with respect to a payee has been pending at least eighteen (18) months).

Sec. 11.18 **General Provisions.** Inactive HC Accounts shall be forfeited and closed under the following circumstances:

- The HC Account has a balance of $1.00 or less; and
- the Participant of the HC Account has not submitted a claim for a concurrent 18 month time period; and
- the HC Account has not received an employer contribution for a concurrent 18 month time period; nor is it scheduled to receive a future employer contribution.

These inactive accounts shall be closed and the forfeited funds shall be placed in a forfeiture account to be used to defray administrative and recordkeeping expenses incurred by the third party administrator they shall not be return to the plan sponsor. This forfeiture process sonly applies to funded Health Reimbursement Arrangements it does not apply to general ledger Health Reimbursement Arrangements.

ARTICLE XII
HIPAA PRIVACY AND SECURITY PROVISIONS

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E ("Privacy Rule") provide that a covered health plan can only disclose protected health information to the sponsor of the plan if the plan's terms and provisions restrict the use and disclosure of the protected health information by the sponsor. HIPAA and the Security Standards and Implementation Specifications at 45 C.F.R. part 160 and part 164, subpart C ("Security Rule") provide that a covered health plan can only disclose electronic protected health information to the sponsor of the plan if the plan's terms require the sponsor to safeguard the electronic protected health information.

Sec. 12.1 **Definitions.** When the following terms are used with initial capital letters, they shall have the meanings set forth below. Terms used, but not otherwise defined below, shall have the same meanings as those terms in Section 1 of the Plan and in the Privacy Rule or the Security Rule.

(a) **Administrative Functions** — shall include, but is not limited to, the following uses and disclosures:

(1) for the purposes of Payment;

(2) for Health Care Operations;

(3) to a Business Associate who has signed a contract limiting its ability to use and disclose PHI and requiring them to implement appropriate safeguards;

(4) to a covered health care provider, a covered healthcare clearinghouse, or another covered health plan for payment activities of such covered entity receiving the information;

(5) to another group health plan sponsored by the Plan Sponsor, which, with the Covered Entity, form an organized health care arrangement;

(6) to provide Participants with information about treatment alternatives or other health-related benefits and services that may be of interest;

(7) as Required By Law;

(8) to respond to court or administrative order, subpoena, discovery request or other lawful process if (i) the information sought is relevant and material to a legitimate law enforcement inquiry, (ii) the request is specific and limited in scope reasonably practicable in light of its purpose, and (iii) de-identified (as defined in the Privacy Rule) information could not reasonably be used;

(9) to public health authority, law enforcement official or other appropriate government authority for public health activities; to lessen a serious and imminent threat to individual or public health or safety; to report abuse, neglect or domestic violence or other law enforcement purposes;

(10) to the extent authorized by and necessary to comply with workers' compensation laws or similar programs;

(11) to a health oversight agency for health oversight activities authorized by law;

(12) to the Secretary of the Department of Health and Human Services for the purpose of determining compliance with the Privacy Rule; and

(13) and any other activities considered administrative functions under the Privacy Rule.

If Covered Entity is permitted or required to use or disclose Protected Health Information or Summary Health Information to a third party in accordance with the Privacy Rule, and an Authorized Employee is required to act on behalf of Covered Entity, then such use or disclosure by Authorized Employee shall be considered an Administrative Function unless the Privacy Rule expressly provides that such use or disclosure is not considered an Administrative Function.

Administrative Functions shall not include: (i) employment-related functions or functions in connection with any other benefits or benefit plan; and (ii) enrollment functions performed by the Plan Sponsor on behalf of its employees.

(b) **Authorized Employees** — employees or classes of employees or other persons under Plan Sponsor's control to the extent they are performing Administrative Functions for or on behalf of Covered Entity.

(c) **Business Associate** — any entity or person who, on behalf of the Covered Entity, performs or assists in the performance of a function or activity involving the use or disclosure of PHI or uses PHI to provide legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to the Covered Entity. It does not include any Authorized Employee or other member of the Employer's workforce.

(d) **Covered Entity** — the Plan.

(e) **Electronic Protected Health Information ("ePHI")** — "Electronic Protected Health Information" shall mean information that comes within paragraph 1(i) or 1(ii) of the definition of "protected health information," as defined in 45 C.F.R. § 160.103.

(f) **Health Care Operations** — means:

(1) Conducting quality assessment and improvement activities, including population based activities relating to improving health or reducing health care costs, case management and care coordination, contacting Participants with information about treatment alternatives; and related functions that do not include treatment.

(ii) 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 claims for health care (including stop loss and excess of loss insurance).

(iii) Conducting and arranging for legal services and auditing functions, including fraud and abuse detection and compliance programs.

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

(v) Business management and general administrative activities of the entity, including, but not limited to:

(1) management activities relating to the implementation of and compliance with the Privacy Rule;

(2) customer service activities;

(3) resolution of internal grievances; and

(4) the sale, transfer, merger or consolidation of all or a part of the covered entity with another covered entity or an entity that following such transaction will become a covered entity and related due diligence.

(vi) Reviewing the performance of any group health plan sponsored by the Employer that participates in an organized health care arrangement.

(g) **Payment** — refers to most activities related to making or securing payment for providing health care and includes, but is not limited to:

(i) determination of premiums;

(ii) obtaining or providing reimbursement for the provision of health care;

(iii) Coverage determination, eligibility determination, coordination of benefits, determination of cost sharing amounts, claims adjudication, review of claims appeals, subrogation of claims;

(iv) Assisting Participants with claims issues and coverage questions;

(v) Claims management, collection activities, obtaining payment under a contract for reinsurance (including stop loss insurance and excess loss insurance) and related health care data processing;

(vi) Review of health care services for medical necessity, coverage, appropriateness of care, or justification of charges; and

(vii) Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services, medical cost containment, utilization management.

(h) **Protected Health Information or PHI** — means health information including demographic information collected from an individual, that:

(i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that either identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; provided that Protected Health Information shall not include: (1) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (2) health care records of post-secondary degree students, as described at 20 U.S.C. 1232g(a)(B)(iv); and (3) employment records held or maintained by the Employer.

(i) **Required By Law** — a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required By Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

(j) **Security Incident** — "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. § 164.304.

(k) **Summary Health Information** — Individually Identifiable Health Information that summarizes the claims history, claims experiences, or type of claims experienced by individuals for whom benefits have been provided under the Covered Entity and from which certain identifiers have been deleted, except that geographic information may only be aggregated to the level of a five-digit zip code.

Sec. 12.2 **Use and Disclosure of PHI.**

(a) Disclosure of Summary Health Information to Plan Sponsor without Authorization. Without an authorization from the subject of the PHI, Covered Entity and Authorized Employees may disclose Summary Health Information to Plan Sponsor for purposes of:

(i) obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Covered Entity (except for genetic information, as defined under the Privacy Rule; or

(ii) modifying, amending, or terminating the Covered Entity, or any health care component of the Covered Entity.

(b) Disclosure of PHI to Plan Sponsor without Authorization. Covered Entity may disclose PHI to Plan Sponsor for purposes of determining whether an individual is participating in the Covered Entity or, in the case of an insured health plan or HMO, is enrolled in or disenrolled from.

(c) Disclosure of PHI to Authorized Employees Without Authorization. Subject to the minimum necessary requirement set forth in subsection (e), below, and the Plan Sponsor certifying to the implementation of the requirements set forth in Section 12.3, Covered Entity may disclose PHI to Authorized Employees for the purpose of performing Administrative Functions.

(d) Disclosure pursuant to an Authorization. Pursuant to an authorization that satisfies the requirements of the Privacy Rule, Covered Entity may disclose PHI to Plan Sponsor, to an Authorized Employee, or to any other person identified in the authorization ("recipient") and such recipient may further use or disclose such PHI for any purpose specified in the authorization.

(e) Minimum Necessary Use and Disclosure. Covered Entity shall make reasonable efforts to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure as required by the Privacy Rule.

Sec. 12.3 **Certified Obligations of Plan Sponsor.**

(a) Certification. Plan Sponsor certifies that it has adopted and implemented the terms and provisions set forth in this Article XII.

(b) PHI Certification. With respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) created, received, maintained, used or disclosed by the Plan Sponsor and/or any Authorized Employee from or on behalf of the Covered Entity, Plan Sponsor agrees to the following requirements and limitations:

(i) Prohibition on Unauthorized Use or Disclosure. Plan Sponsor and/or any Authorized Employee will not use or further disclose such PHI, except as permitted or required by this Article XII or as Required By Law.

(ii) Subcontractors and Agents. Plan Sponsor will ensure that any agents, including a subcontractor, to whom such PHI is provided agree to the same restrictions and conditions that apply to Plan Sponsor.

(iii) Prohibition on Employment-Related Actions. Plan Sponsor and/or any Authorized Employee will not use or disclose such PHI for employment-related actions and decisions in connection with any other benefit or employee benefit plan sponsored by Plan Sponsor.

(iv) Duty to Report Violations. To the extent Plan Sponsor and/or an Authorized Employee becomes aware of any use or disclosure that is inconsistent with the uses or disclosures permitted under this Article XII, Plan Sponsor and/or the Authorized Employee will report such inconsistent uses or disclosures to Covered Entity.

(v) Access to PHI. Upon a request by an individual participating in Covered Entity, Plan Sponsor and/or any Authorized Employee responsible for handling requests for access will provide such individual with access to his or her PHI.

(vi) Amendment of PHI. Upon a request by an individual participating in Covered Entity, Plan Sponsor and/or any Authorized Employee responsible for handling

requests for amendment will respond to such individual's request and incorporate any approved amendments to such PHI.

(vii) Accounting of Disclosures. Upon a request by a an individual participating in Covered Entity, Plan Sponsor and/or any Authorized Employee responsible for accounting for disclosures of PHI will provide such individual with an accounting of disclosures.

(viii) Inspection of Books and Records. Plan Sponsor will make internal practices, books, and records relating to the use and disclosure of such PHI available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with the Privacy Rule.

(ix) Retention of PHI. Plan Sponsor and/or any Authorized Employee will, if feasible, return or destroy all such PHI that it maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, Plan Sponsor and/or any Authorized Employee will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(x) Firewall. Plan Sponsor will ensure that adequate separation between Covered Entity, Authorized Employees, and Plan Sponsor is established and maintained in accordance Sec. 12.4.

(c) ePHI Certification. With respect to any ePHI (other than enrollment/disenrollment information and Summary Health Information which are not subject to these restrictions) created, received, maintained or transmitted by Plan Sponsor and/or any Authorized Employee from or on behalf of Covered Entity, Plan Sponsor and Authorized Employee shall:

(i) Subcontractors and Agents. Plan Sponsor will ensure that any agents, including independent contractors and subcontractors, to whom ePHI is provided from the Covered Entity, agree to implement reasonable and appropriate security measures to protect the ePHI.

(ii) Safeguards. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(iii) Security Incident Reporting. Plan Sponsor will report to the Covered Entity any Security Incident of which it becomes aware, except that, for purposes of this reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis such as scans or "pings" that are not allowed past Plan Sponsor's firewall.

Sec. 12.4 **Adequate Separation.**

(a) Adequate Separation of Covered Entity, Authorized Employees and Plan Sponsor. Covered Entity shall allow only the following Authorized Employees to have access to or use of PHI:

(i) The benefits manager; and

(ii) Staff designated by the benefits manager.

The Plan Sponsor shall identify, by name, these persons in writing to the Claims Administrator.

(b) Compliance Requirements.

(i) Access and Use. Authorized Employees shall have access to and use of PHI only for the purposes of performing Administrative Functions for the Covered Entity and certain other functions Required By Law. Plan Sponsor will ensure the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures to the extent that Authorized Employees have access to ePHI.

(ii) Compliance. For purposes of performing any Administrative Function, an Authorized Employee shall comply with the requirements of Sec. 12.3 and the privacy and security policies and procedures of the Covered Entity.

(iii) Resolution of Any Issues of Noncompliance. Authorized Employees shall be sanctioned or disciplined up to and including termination of employment for failure to comply with the privacy and security policies and procedures of the Covered Entity.

ARTICLE XIII
COBRA CONTINUATION COVERAGE

Note: Adopting Employers with fewer than twenty (20) Employees are not subject to COBRA.

Sec. 13.1 **Generally.** The Plan is a group health plan that, unless the Adopting Employer is not subject to COBRA, is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. If COBRA is applicable, COBRA procedures shall be established and followed consistent with applicable law.

Sec. 13.2 **Notification Procedures.** The Plan requires the notifications described below with respect to continuation coverage under COBRA:

(a) Notice of qualifying event. Under the law, a Covered Individual (or a representative acting on behalf of the Covered Individual) has the responsibility to inform the Plan of a divorce, legal separation, or a child losing dependent status under the Plan (the "qualifying event") within sixty (60) days of the latest of: (i) the date of the qualifying event; (ii) the date coverage would be lost because of the qualifying event; or (iii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Plan. Oral notification, including notification by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the qualifying event;

(4) include a detailed description of the event;

(5) identify the effective date of the event; and

(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

(b) Notice of second qualifying event. A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(4) identify the nature and date of the initial qualifying event that entitled the Covered Individuals to COBRA coverage;

(5) include a detailed description of the event;

(6) identify the effective date of the event; and

(7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

(c) Notice of disability. A Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan when a Covered Individual has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (i) the date of the disability determination; (ii) the date of the qualifying event; (iii) the date coverage would be lost because of the qualifying event; or (iv) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. Notwithstanding the foregoing, notification must be provided before the end of the first eighteen (18) months of continuation coverage. The notification must be provided in writing and be mailed to the Plan. Oral notification, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered

notices are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all Covered Individuals who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(4) identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage;

(5) state the name of the disabled Covered Individual;

(6) identify the date upon which the disabled Covered Individual became disabled;

(7) identify the date upon which the Social Security Administration made its determination of disability; and

(8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan of that determination within thirty (30) days of the later of: (i) the date of such determination; or (ii) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be in writing and be mailed to the Plan. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If the notification is not provided within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

(d) Notice of Coverage Under Another Group Health Plan or Medicare. A Covered Individual must notify the Plan immediately if any Covered Individuals receiving continuation coverage actually become covered by another group health plan (besides a group health plan integrated with this Plan) or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a Covered Individual on continuation coverage receives any benefits under the Plan after coverage is to cease under

the foregoing rule, the Plan reserve the right to seek reimbursement from such Covered Individual.

Sec. 13.3 **Alternative in Lieu of COBRA Continuation.**

(a) Following termination of employment, a Covered Individual (and the Covered Individual's Spouse and Dependents) will be allowed to spend down the balance of their HC Account if they choose to continue to access their HC Account in lieu of COBRA continuation coverage. If the Covered Individual chooses to spend down their HC Account, the Covered Individual (and their Spouse and Dependents) may generally continue to submit claims for Health Care Expenses until the earlier of: (i) the fifth (5th) anniversary of the date of the Participant's termination of employment, or (ii) the account balance reaches zero.

(b) Upon the death of a Covered Individual, the Covered Individual's surviving Spouse and Dependents will be allowed to spend down the balance of the Covered Individual's HC Account if they choose to continue to access the Covered Individual's HC Account in lieu of COBRA continuation coverage. If they choose to spend down the Covered Individual's HC Account, the Covered Individual's surviving Spouse and Dependents may generally continue to submit claims for Health Care Expenses until the account balance reaches zero.

The Plan Administrator also reserves the right to offer other alternatives to COBRA to the extent not precluded by applicable law. The provisions of the Plan concerning COBRA requirements shall be administered consistent with good faith interpretations of applicable law.