CELINA CITY BOARD OF EDUCATION PLAN DOCUMENT

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

The attached plan document and adoption agreement are being provided for illustrative purposes only. Because of differences in facts, circumstances, and the laws of the various states, interested parties should consult their own attorneys. This document is intended as a guide only, for use by legal counsel.

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HEALTH REIMBURSEMENT ARRANGEMENT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Health Reimbursement Arrangement Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	Celina City Board of Education
Address:	585 E Livingston St Celina, OH 45822
Employer Identification Number:	34-6400269
Nature of Business:	Public School
Name of Plan:	Celina City Board of Education Health Reimbursement Arrangement Plan
Plan Number:	502

B. EFFECTIVE DATE

Original effective date of the Plan:	January 1, 2019
If Amendment to existing plan, effective date of amendment:	

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

An individual who satisfies the following requirements may participate in this Health Reimbursement Arrangement Plan:

Employee must be enrolled in Employer's medical insurance. Employee must work at least 6 hours per day. Employee is eligible on first day of employment.

D. PLAN YEAR

The current Plan Year will begin on January 1, 2019 and end on December 31, 2019. Each subsequent Plan Year will begin on January 1 and end on December 31.

E. CREDITS TO ACCOUNTS

The maximum annual amount credited to a Participant's Account will be:

$1,225.00 for Employee Only and $2,450.00 for Family

Credits to the Participants' Account will be made

Up Front with Semi-Annual Contributions in January and July

In the event of a short Plan Year, the maximum annual amount, and if applicable, the periodic credits to the Participants' Accounts will be pro rated accordingly (i.e., the maximum amount allowed for a short Plan Year is the annual amount set forth above multiplied by the number of months in the short Plan Year, divided by 12).

In the event of newly hired or newly eligible Participants during a Plan Year, the maximum annual amount, and if applicable, the periodic credits to the Participants' Accounts will be pro rated accordingly (i.e., the maximum amount allowed for a short Plan Year is the annual amount set forth above multiplied by the number of months in the short Plan Year, divided by 12).

F. **UNUSED ALLOCATIONS**: Unused Account balances at each Plan Year end will be carried over to the next Plan Year. If carried over, the maximum annual amount that can be carried over will not be limited.

G. **LIMITATION OF MEDICAL EXPENSES**: The Medical Expenses that will be reimbursed under this Plan shall be limited to the following (if applicable, reimbursements will be limited to EOBs from the specific carrier as indicated):

Any eligible 213(d) expenses

This Plan is not available for reimbursement of such Medical Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Notwithstanding the foregoing, and subject to the other requirements of this Plan, preventive care services required to be provided pursuant to Public Health Service Act Section 2713, as added by the Affordable Care Act, will be considered Medical Expenses that are eligible for reimbursement under the terms of this Plan.

H. **DEBIT CARDS:** The provisions of Article 5.07 of the Plan to permit the offer of the Debit Card are elected.

I. ADOPTION OF THE PLAN:

The Plan shall be governed, construed, enforced, and administered in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and to the extent not preempted by federal law, the laws of the State of OH. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted _____.

Celina City Board of Education
(Name of Employer)

By: _____

Title: ASST TREASURER

APPENDIX A: RELATED EMPLOYERS

The following is the list of Related Employers that participate in the Plan:

N/A

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HEALTH REIMBURSEMENT ARRANGEMENT PLAN

ARTICLE I: PURPOSE

The Employer hereby establishes this Health Reimbursement Arrangement Plan in order to enable Eligible Employees to obtain reimbursement of Medical Expenses on a nontaxable basis from their Accounts.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

This Plan is intended to qualify as an employer provided medical reimbursement plan under Code Sections 105 and 106 and the regulations promulgated thereunder, and as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Plan shall be construed and administered in accordance with such intent.

ARTICLE II: DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 Account: A Participant's separate bookkeeping account maintained by the Employer in accordance with Article 5.04 hereof that reflects the amount of Benefits available to the Participant under this Plan.

2.02 Administrator: The Employer unless another entity or person has been designated in writing by the Employer as the Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.03 Benefits: The reimbursement benefits for Medical Expenses under this Plan.

2.04 COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time and codified in Code Section 4980B. Any reference to COBRA will be deemed to include any applicable regulations and rulings pertaining to COBRA and will also be deemed a reference to comparable provisions of future laws.

2.05 Code: Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code will be deemed to include any applicable regulations and rulings pertaining to such section and will also be deemed a reference to comparable provisions of future laws.

2.06 Dependent: Either of the following:

(a) Tax Dependent: A Dependent includes a Participant's Spouse and any other person who is a Participant's dependent within the meaning of Code Section 152; provided that a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and

(d)(1)(B) thereof, and (ii) includes any child of the Participant to whom Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Adult Children: A Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A "child" for purposes of this Article 2.07(b) means any individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Notwithstanding the forgoing, the Plan will provide Benefits with the applicable requirements of any QMCSO even if the child does not meet the definition of "Dependent."

2.07 Effective Date: The Effective Date of this Plan as shown in Item B of the Adoption Agreement.

2.08 Eligible Employee: An Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.

2.09 Employee: Any person employed by the Employer on the basis of an Employer-Employee relationship who receives remuneration for personal services rendered to the Employer, but excluding the following:

(i) any leased Employee within the meaning of Code Section 414(n)(2);
(ii) any person who has been classified by the Employer as an independent contractor and has had his compensation reported to the Internal Revenue Service on Form 1099 but who has been reclassified as an "Employee" (other than by the Employer), provided that if the Employer does reclassify such worker as an "Employee" for purposes of this Plan, such reclassification shall only be prospective from the date that the Employee is notified by the Employer of such reclassification;
(iii) any self-employed individual;
(iv) any partner in a partnership; and
(v) any person who owns more than 2% of the outstanding stock of a Subchapter S corporation, including a person deemed to own more than 2% by virtue of the ownership attribution rules of Code Section 318.

2.10 Employer: The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan. For the purposes of Article VII, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.

2.11 Entry Date: The date that an Employee is eligible to participate in the Plan, as specified in Item C of the Adoption Agreement.

2.12 ERISA: The Employee Retirement Income Security Act of 1974 as amended from time to time. Any reference to any section of ERISA will be deemed to include any applicable regulations and rulings pertaining to such section and will be deemed a reference to comparable provisions of future laws.

2.13 Health FSA: A health flexible spending arrangement as described in Prop. Treas. Reg. Section 1.125-5 and maintained by the Employer for its Employees.

2.14 Major Medical Plan: The plan(s) that the Employer maintains for its Employees (and for their Dependents who may be eligible under the terms of such plan(s)), providing major medical type benefits through a group insurance policy or policies or through self-insurance.

2.15 Medical Expenses: Expenses identified in Item G of the Adoption Agreement that are incurred by a Participant or his or her Dependents for medical care, as defined in Code Section 213(d), and insurance premiums incurred by a retiree for a group health plan sponsored by the Employer as provided in Item G of the Adoption Agreement, as defined in Code Sections 213(d)(1)(A) and (B),but not including health insurance premiums for individual policies. Medical Expenses are limited as provided in Item G of the Adoption Agreement. Notwithstanding the foregoing, beginning January 1, 2011, the Employer may only elect the following drugs or medicines to constitute Medical Expenses:

(a) Drugs or medicines that require a prescription;
(b) Drugs or medicines that are available without a prescription ("over-the-counter" drugs or medicines) and for which the Participant or Dependent obtains a prescription; and
(c) Insulin.

2.16 Participant: An Eligible Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement and is participating in the Plan in accordance with the provisions of Article III hereof.

2.17 Period of Coverage: The Plan Year, with the following exceptions:

(a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Article 3.01; and
(b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Article 3.03.

A different Period of Coverage (e.g., monthly) may be established by the Administrator and communicated to Participants.

2.18 Plan: The Plan referred to in Item A of the Adoption Agreement, as may be amended from time to time.

2.19 Plan Year: The Plan Year as specified in Item D of the Adoption Agreement.

2.20 QMCSO: A qualified medical child support order, as defined in ERISA Section 609(a).

2.21 Recordkeeper: The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Plan.

2.22 Related Employer: Any affiliated entity authorized to participate in the Plan by the Employer, as listed in Appendix A of the Adoption Agreement.

2.23 Spouse: An individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

ARTICLE III: ELIGIBILITY AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date, whichever is later. An Eligible Employee's enrollment in the Plan shall be automatic.

The Employer is authorized to classify which individuals are eligible or ineligible. In the event the classification of an individual who is excluded from eligibility is determined to be erroneous or is retroactively revised, the individual will nonetheless be excluded from eligibility for all periods prior to the date the classification is determined to be erroneous or is revised and will continue to be excluded from eligibility for future periods, unless otherwise determined by the Employer.

3.02 TERMINATION OF PARTICIPATION:

(a) In General: A Participant shall continue to participate in the Plan until the earliest of the following dates:

i. The date the Participant terminates employment by death, disability, retirement or other separation from service;
ii. The date the Participant ceases to work for the Employer as an Eligible Employee; or
iii. The date of termination of the Plan.

Reimbursements from the Account after termination of participation will be made pursuant to Section 5.08 (relating to a run-out period for submitting claims incurred prior to termination of employment and relating to COBRA).

(b) In the Case of Fraud: To the extent allowed by applicable law, the Administrator, in its sole and absolute discretion, may terminate coverage for a Participant (or other individual), or require such individual to repay the Plan for reimbursements already made, if the Participant, or his Spouse or Dependent obtains or attempts to

obtain benefits (for themselves or any other individual) by means of fraudulent information, acts, or omissions or intentional misrepresentation of material fact. In such case, coverage under this Plan may be rescinded retroactively or cancelled prospectively at the discretion of the Administrator. In the case of retroactive cancellation, coverage will not be rescinded until the Administrator provides 30 days notice to the affected Participant.

3.03 QUALIFYING LEAVE UNDER FAMILY AND MEDICAL LEAVE ACT OR USERRA: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), to the extent required by the FMLA or USERRA, the Employer will continue to maintain the Participant's existing coverage under the Plan on the same terms and conditions as though he were still an active Employee pursuant to the Employer's leave of absence policy.

ARTICLE IV: CONTRIBUTIONS AND FUNDING

4.01 EMPLOYER CONTRIBUTIONS: The Employer funds the full amount of the Accounts. There are no Participant contributions for Benefits under the Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, flex credits, or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

4.02 FUNDING THIS PLAN: All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the 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 Employer from which any payment under this Plan may be made. The Employer may establish a separate account from which to pay Benefits, but there is no requirement to do so.

ARTICLE V: HEALTH REIMBURSEMENT BENEFITS

5.01 BENEFITS: The Plan will reimburse Participants for Medical Expenses up to the unused amount in the Participant's Account, as set forth and adjusted under Section 5.04. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Expenses.

5.02 ELIGIBLE MEDICAL EXPENSES: A Participant may receive reimbursement for Medical Expenses incurred during a Period of Coverage during which the Participant is a Participant in the Plan.

(a) Incurred: A Medical Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the

expense is formally billed for, is charged for, or pays for the medical care. Medical Expenses incurred before a Participant first becomes covered by the Plan are not eligible for reimbursement. However, a Medical Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the Participant was a Participant in the Plan during both Periods of Coverage.

(b) Cannot Be Reimbursed or Reimbursable from Another Source: Medical Expenses can only be reimbursed to the extent that the individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Major Medical Plan, other insurance, any other accident or health plan, or any other source (such as a recovery from a third party). If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the Major Medical Plan imposes co-payment or deductible limitations), the Account can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of this Article V.

(c) Coordination of Benefits with Health FSA: Benefits under this Plan are intended to pay Benefits solely for Medical Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Expense is payable or reimbursable from another source, that other source shall pay or reimburse the Medical Expense prior to payment or reimbursement from this Plan. This Plan shall be the payer of last resort.

Without limiting the foregoing, if the Participant's Medical Expenses are covered by both this Plan and by a Health FSA, the Employer will designate in Item G of the Adoption Agreement if this Plan is or is not available for reimbursement of Medical Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

5.03 MAXIMUM BENEFITS:

(a) Maximum Benefits: The maximum dollar amount that may be credited to an Account for an Employee who participates for an entire 12-month Period of Coverage, or who incurs a short Plan Year because of being newly hired or newly eligible, is set forth in Item E of the Adoption Agreement.

(b) Changes: For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the summary plan description or another document.

(c) Nondiscrimination: Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Administrator in its sole discretion. Such limitation may be imposed whether or not it results in a forfeiture.

5.04 ESTABLISHMENT OF ACCOUNT: The Administrator will establish and maintain an Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a notional

recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts: A Participant's Account will be credited at the beginning of each month, quarter, or Plan Year as elected by the Employer in Item E of the Adoption Agreement. If the Employer has elected annual credits in Item E of the Adoption Agreement, the amount of the credit on the first day of the Plan Year shall be equal to the applicable maximum dollar limit for the Period of Coverage. If the Employer has elected quarterly or monthly crediting of Accounts, the amount of each credit to each Participant's Account at the beginning of each month or quarter shall be a pro rata portion of the applicable maximum annual dollar limit for the Period of Coverage, increased by any carryover of unused Account balance from a prior Period of Coverage (if elected by the Employer in Item F of the Adoption Agreement).

(b) Debiting of Accounts: A Participant's Account will be debited during each Period of Coverage (or 90-day period following the close of the Plan Year in which a Medical Expense was incurred, if applicable) for any reimbursement of Medical Expenses incurred during the Period of Coverage.

(c) Available Amount: The amount available for reimbursement of Medical Expenses is the amount credited to the Participant's Account under Subsection (a) reduced by prior reimbursements debited under Subsection (b).

(d) Mid-Year Credit Changes. If the Employer has elected monthly crediting of Accounts in Item E of the Adoption Agreement, then, in the event of a mid-year gain or loss of eligibility for a specific level of coverage by a Participant, credits to the Account of that Participant for the remainder of the Plan Year will be calculated by prorating the difference in the coverage levels for the remainder of the Plan Year and either adding that number to or subtracting that number from the previously calculated credits for the remaining months of the Plan Year, as applicable.

(e) Special Rule for Certain COBRA Qualifying Events: If a Participant's Spouse or Dependent child loses coverage under the Plan as a result of a divorce or a child ceasing to be an eligible Dependent under the Plan, to the extent required by COBRA, the Participant's Spouse and/or Dependents (Qualified Beneficiaries), whose access to the Account terminates because of a COBRA qualifying event, shall be given the opportunity (on a self-pay basis) to continue to have access to certain Account funds. If the Participant's Spouse and/or Dependent(s) elect COBRA continuation coverage and pay all required premiums when due, the Administrator will establish a new Account on behalf of the Spouse or Dependent and they will continue to receive any credits due under Section 5.04(a). The Available Amount in the Participant's Account (if any) will be split between the Participant's HRA and the Spouse or Dependent's new HRA based on the terms of any agreement between the Participant and his Spouse or Dependent(s). In the absence of an agreement, the Administrator will split the Available Amount based

on the number of individuals assigned to each Account. For example, if the Participant and his former spouse get divorced and the former spouse elects COBRA coverage on behalf of herself and the couple's two minor children, then ¾ of the Available Amount will be credited to the new Account and ¼ of the Available Amount will remain in the Participant's Account. Future credits will be allocated based on the same formula used to divide the Available Amount at the time of the qualifying event.

In the event that coverage under the Plan is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is exhausted, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

5.05 UNUSED ALLOCATIONS: If any balance remains in the Participant's Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance will remain available to reimburse the Participant for Medical Expenses incurred during the next subsequent Period of Coverage as described in Item F of the Adoption Agreement. Upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected as provided in Article 5.08, or Item F of the Adoption Agreement extends the ability to incur and submit Medical Expenses for reimbursement. In addition, any Benefit payments that are unclaimed (e.g., uncashed Benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Expense was incurred shall be forfeited to the Employer. Notwithstanding anything to the contrary herein, the maximum accrued Account balance shall be limited to the amount elected in Item F of the Adoption Agreement if the Employer in fact elects to limit such amount.

5.06 REIMBURSEMENT PROCEDURE:

(a) Timing: Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim. See Article 6.07 regarding the Plan's claims review procedure.

(b) Claims Substantiation: A Participant who seeks Benefits may apply for reimbursement by submitting an expense reimbursement voucher in writing to the Administrator in such form as the Administrator may prescribe, by no later than

90 days following the close of the Plan Year in which the Medical Expense was incurred, setting forth:

(i) The person or persons on whose behalf Medical Expenses have been incurred;
(ii) The nature and date of the Medical Expenses so incurred;
(iii) The amount of the requested reimbursement; and
(iv) A statement that such Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Expenses has been exhausted.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Expenses have been incurred and the amounts of such Medical Expenses, together with any additional documentation that the Administrator may request.

5.07 USE OF DEBIT CARDS: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses under the Plan, the provisions described in this Article shall apply. However, a Debit Card may not be used to purchase over-the-counter drugs and medicines.

(a) Substantiation: The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card (other than over-the-counter drugs or medicines) to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan covering the specific Employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.
(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

(b) Status of Charges: All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

(c) Correction Procedures for Improper Payments: In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Participant will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Participant does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Participant's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Participant will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and Administrator may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Participant.

(d) Intent to Comply with Rev. Rul. 2003-43: It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in Rev. Rul. 2003-43, and this Article 5.07 shall be construed and interpreted in a manner necessary to comply with such guidelines.

5.08 REIMBURSEMENTS AFTER TERMINATION; COBRA: When a Participant ceases to be a Participant under Article 3.02, the former Participant will not be able to receive reimbursements for Medical Expenses incurred after his or her participation terminates. However, such former Participant (or the former Participant's estate) may claim reimbursement for any Medical Expenses incurred during the Period of Coverage prior to termination of participation, provided that the former Participant (or the former Participant's estate) files a claim by 90 days following the close of the Plan Year in which the Medical Expense was incurred.

To the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

In the event that coverage under this Plan is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is discontinued, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

5.09 REIMBURSEMENTS AFTER TERMINATION OF EMPLOYMENT; SPEND-DOWN: When a Participant ceases to be a Participant under Article 3.02, the former Participant will not be able to receive reimbursements for Medical Expenses incurred after his or her participation terminates unless the Adoption Agreement in Item F permits such individual to continue to incur and submit Medical Expenses for reimbursement. Former Employees will continue to be eligible to incur and submit expense for reimbursement from the Plan for the period specified in the Adoption Agreement following the date of termination. Participants are eligible for additional Allocations after the date of termination if COBRA is elected. This spend-down period will run concurrently with COBRA.

ARTICLE VI: ADMINISTRATION

6.01 NAMED FIDUCIARY: The Administrator shall be the named fiduciary of the Plan.

6.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Plan.

6.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR: The Administrator will have the duties and obligations to carry out the terms and conditions of the Plan. With the discretionary authority authorized by Article 6.04, the duties and powers of the Administrator will include, but will not be limited to the following:

(a) General: The Administrator shall be vested with all powers and authority necessary in order to administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of Benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons. Benefits will be paid only if the Administrator or its delegate determines, in its discretion, that the applicant is entitled to them.

Without limiting the generality of the foregoing, the Administrator shall have the following authority:

(i) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to

decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

(ii) to prescribe procedures to be followed and the forms to be used by Employees and Participants to submit claims pursuant to this Plan;

(iii) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

(iv) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(v) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(vi) to receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

(vii) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(viii) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(ix) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(x) to maintain the books of Accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

(b) Recordkeeping: The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA.

(c) Inspection of Records: The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the Accounts or records with respect to other Participants.

6.04 DISCRETION OF ADMINISTRATOR: The Administrator (or its delegate, such as the Recordkeeper) for this Plan has the sole and absolute discretionary authority to perform its duties in connection with the Plan. The Administrator's decisions made in good faith will be conclusive and binding on all persons, including but not limited to any Employee or Dependent. Decisions will be made in accordance with the governing Plan documents, the Code, and ERISA, and, where appropriate, Plan provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The

Administrator will have the discretion to determine which claimants are similarly situated in similar circumstances.

6.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

6.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

6.07 CLAIMS REVIEW PROCEDURE:

(a) Definitions. The following definitions apply to this Article describing the claims submission and the benefits appeal process.

(i) **Adverse benefit determination** means a denial of Benefits under the Plan, including any reduction or termination by the Plan of a course of treatment (other than by Plan amendment or termination), a failure to make a payment based on a determination of the claimant's eligibility to participate in the plan, and with respect to health benefits, a denial, reduction, or termination of (or a failure to provide or make payment in whole or in part for) a benefit resulting from the application of a utilization review or a failure to cover an item or service because it is determined to be experimental, investigational, or not medically necessary or appropriate. In addition, with respect to major medical benefits, an adverse benefit determination includes any rescission of coverage, which means a cancellation or discontinuance of coverage that has retroactive effect.

(ii) **External review** means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in the external review section below.

(iii) **Final internal adverse benefit determination** means an adverse benefit determination that has been upheld by the Administrator at the completion of the internal appeals process.

(iv) **Final external review decision** means a determination by an independent review organization at the conclusion of an external review.

(iii) **Independent Review Organization (or IRO)** means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

(iv) **Internal review** (including references to internal claim determinations and internal appeals) means a review of a claim or appeal of an adverse benefit determination made by the Administrator.

(vi) **Participant**, for purposes of this section, includes a Participant's authorized representative.

(b) Initial Claims. To obtain benefits under the Plan a Participant must submit a claim for benefits in the manner prescribed by the Administrator. The Participant must file the claim within 90 days after the end of the Plan Year in which the claim arose.

The Administrator will notify the Participant of its claims determination within a reasonable period of time, but not later than 30 days after receipt of the claim, unless the Administrator notifies the Participant that an extension of up to 15 days is necessary due to circumstances beyond the Administrator's control. If the reason for the extension is because the Administrator does not have enough information to decide the claim, the notice will describe the required information, and the Participant will have at least 45 days from the date the notice is received to provide the necessary information, and the period for making the benefit determination will be tolled from the date the notice is sent to the Participant until the date that the claimant provides the necessary information.

(c) Contents of Initial Claim Denial Notices. If an initial claim is denied, the Participant must be given written notice that includes:

(i) The specific reason or reasons for the adverse benefit determination;

(ii) Reference to the Plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why the information is necessary;

(iv) A description of the Plan's review procedures and the time limits applicable to those procedures, including a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review;

(v) If an internal rule or guideline was applied in making the determination, an explanation of the rule or a statement that the rule will be provided free of charge upon request; and

(vi) If the determination is based on a medical necessity or experimental exclusion, an explanation of the scientific or clinical judgment applied to make the determination or a statement that the explanation will be provided free of charge upon request.

(d) Appealing an Initial Claims Denial: If the initial claim is denied, the Participant will have 180 days from receipt of notification to appeal the determination. The Participant may submit written comments, documents, records, and other information relating to the claim for consideration on appeal. The Participant must be provided, upon request and free of charge, reasonable access to and copies of all other information relevant to the Participant's claim. For this purpose, information will be considered relevant if it (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated (without regard to whether it was relied upon) in the course of making the benefit determination, (3) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Participant's diagnosis (without regard to whether the statement or guidance was relied upon).

The Participant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim. In addition, before the Administrator issues a final internal adverse benefit determination based on a new or additional rationale, the Participant must be provided, free of charge, with the rationale. This information must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is provided to give the Participant a reasonable opportunity to respond prior to that date.

(e) Decisions on Internal Appeal: The Participant must be notified of the determination within a reasonable period of time, but not later than 30 days after receipt of the request for review. If the decision to deny the claim was based in whole or in part on a medical judgment, the reviewing fiduciary must consult with a health care professional who has experience and training in the relevant field and who was not involved in the initial determination. Identification of any such health care professional must be provided to the claimant upon request.

(f) Contents of Notice of Decision on Internal Appeal. Any notice of an adverse benefit determination from an internal appeal must include:

(i) The specific reason or reasons for the adverse benefit determination;
(ii) Reference to the Plan provisions on which the determination is based;
(iii) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the Participant's claim;

(iv) A statement describing the second-level appeal procedures and the Participant's right to obtain information about such procedures, and a statement of the Participant's right to bring an action under ERISA Section 502(a);

(v) If the determination is based on a medical necessity or experimental exclusion, an explanation of the scientific or clinical judgment applied to make the determination, or a statement that the explanation will be provided free of charge upon request;

(vi) If an internal rule or guideline was applied in making the determination, an explanation of the rule, or a statement that the rule will be provided free of charge upon request; and

(vii) A statement that "you or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

A notice of an adverse benefit determination or final internal adverse benefit determination must also include:

(i) Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(ii) The reason or reasons for the adverse benefit determination or final internal adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must include a discussion of the decision;

(iii) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(iv) The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

(g) Making a Second Internal Appeal. Second internal appeals are required before a Participant may pursue an external review or file a lawsuit. If a Participant's first appeal for benefits is denied and the Participant wants to appeal further, the Participant will have 60 days from receipt of the notification of the adverse benefit determination on review to appeal in writing to the Administrator.

The Participant's second appeal must outline the issues and include any additional information and related documents. The provisions described above with respect to appealing an adverse benefit determination on review will also apply to second appeals.

(h) External Review. An external review will be available to the extent required by Federal law. The provisions of this section shall not be interpreted to extend coverage beyond such requirements nor to provide lesser rights than required.

A claimant may request an external review of the Administrator's denial of a claim (in whole or in part) based on a determination that the care is not appropriate or a service or treatment is experimental or investigational in nature. An external review is a review by an independent physician, selected by an Independent Review Organization (IRO) accredited by a nationally recognized private accrediting organization.

An adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the plan is not within the scope of the external review process.

(i) Request for External Review. A Participant may file a request for an external review with the Administrator if:

(i) The Participant received a final internal adverse benefit determination from the Administrator;
(ii) The claim was denied because the Administrator determined that the care was not necessary or was experimental; and
(iii) The Participant has exhausted the applicable internal appeal processes.

The request for external review must be filed within 60 calendar days after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination, and must include a copy of the adverse benefit determination or final adverse benefit determination and all other pertinent information in support of the request. The claimant is responsible for the cost of compiling and sending the information that the claimant wishes to be reviewed by the IRO to the Administrator. The Administrator is responsible for the cost of sending this information to the IRO and for the cost of the external review.

(j) Preliminary Review. Within five business days following receipt of the Participant's request for external review, the Administrator will conduct a preliminary review of the request to determine whether:

(i) The Participant is or was covered under the Plan at the time the Medical Expense item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the Medical Expense item or service was provided;
(ii) The adverse benefit determination or the final adverse benefit determination does not relate to the Participant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(iii) The Participant has exhausted the Plan's internal appeal process unless the Participant is not required to exhaust the internal appeals process under applicable law; and

(iv) The Participant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Administrator will issue a notification to the claimant. If the request is complete but not eligible for external review, the claimant must be notified of the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the claimant must be notified of the information or materials needed to make the request complete and must be allowed to perfect the request for external review, the amount of time for which must be specified in the notification.

(k) Referral to Independent Review Organization. Upon Upon a determination that a request is eligible for external review following the preliminary review, the Administrator must assign an IRO accredited by a nationally recognized private accrediting organization to conduct the external review. The IRO will select an independent physician with appropriate expertise to review the denial, and will issue a final benefits determination within 30 calendar days of the receipt of the claimant's request for external review and all necessary information.

(l) Contents of Notice of Decision on External Review. The IRO will issue a notice of its decision on external review to the Participant. Notices will be provided upon request in a non-English language as needed. Notices will include information about the claim, the IRO's decision, a description of available appeals and external review processes and contact information for any applicable health insurance consumer assistance or ombudsman.

(m) Reversal of Administrator's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

(n) Expedited External Review. An expedited review can be requested if a Participant's physician certifies to the Administrator that the standard timeframes would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function, or if a final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility. An expedited review requires the Administrator to determine immediately if the request is complete and eligible for external review. Documents and information must be submitted to the IRO electronically, by telephone or facsimile, or any other expeditious method. The notice of final external review decision must be completed as expeditiously as

circumstances require, but no more than 72 hours after the IRO receives request for external review.

(o) Exhaustion: All issues must be raised on appeal or will forever be waived. For each issue raised, a Participant must exhaust all internal claims and appeals processes before pursuing external review. In addition, for each issue raised, a Participant must exhaust all claims and appeals processes before pursuing litigation. Under no circumstances may any lawsuit be brought with respect to a claim for benefits more than 180 days following the final adverse benefit determination under the Plan.

(p) Mitigation of Potential Conflicts of Interest. All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. An appeals decision must not afford deference to the initial adverse benefit determination, first internal appeal determination, or second appeal determination (as applicable) and must not be conducted by any individuals who made the initial determination, first appeal determination, or second appeal determination or their subordinates. The review must take into account comments, documents, records, and other information submitted, regardless of whether the information was previously considered on initial review, first internal appeal, or second internal appeal.

In making a claims determination, the Administrator must interpret Plan provisions in good faith in the best interest of Plan Participants and beneficiaries and must not take into account either the amount of benefits that will be paid to a Participant or the financial impact on the company. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual involved in a claims determination will not be made based upon the likelihood that the individual will support the denial of benefits.

6.08 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

6.09 INABILITY TO LOCATE PAYEE: If the 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 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 that any such payment first became due.

6.10 EFFECT OF MISTAKE: In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the

extent that it deems administratively possible and otherwise permissible under Code Section 105, cause to be allocated or cause to be withheld or accelerated, or otherwise made adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the Account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

6.11 PROTECTED HEALTH INFORMATION. The Plan may disclose PHI to Employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164 (the "HIPPA Privacy Rule"). The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or further disclose PHI other than as permitted or required by the Plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to it or on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractor to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available to Plan Participants their PHI in accordance with 45 C.F.R. § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance for purposes of determining compliance with 45 CFR § 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such

information when no longer needed for the purposes for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR § 164.504 is established; and
- comply with the notification requirements in the case of a breach of unsecured PHI, in accordance with Section 13402 of the Health Information Technology for Economic and Clinical Act (HITECH Act) and the regulations and other guidance issued thereunder.

(a) Definition of "PHI." For purposes of this Article, "PHI" is "Protected Health Information" as defined in 45 C.F.R. § 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR § 160.103, that is maintained or transmitted in electronic media or any other form or medium by a covered entity, as defined in 45 C.F.R. § 164.104.

(b) Required Separation between the Plan and the Employer. In accordance with the HIPAA Privacy Rule, the Plan's privacy policy describes the Employees, classes of Employees, or workforce members under the control of the Employer who may be given access to individuals' PHI received from the Plan.

These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of this Article.

The Employer will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

(c) Reporting of Security Incidents. Employer shall report to the Plan any Security Incidents of which it becomes aware as described below:

(i) Employer shall report to the Plan, within a reasonable time after Employer becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

(ii) Employer shall report to the Plan any other Security Incident on an aggregate basis every calendar quarter or more frequently upon the Plan's request. Employer shall have a reasonable period of time after learning of a Security Incident to report any successful attempt to the Plan, but can aggregate the data relating to unsuccessful attempts and report that information to the Plan on a less frequent basis.

(iii) For this purpose, "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

6.12 RIGHT OR RECOVERY. If a Participant or his Dependent receives a reimbursement under the Plan and reimbursement for the same expense is made under another plan or program, the Participant will be required to refund the reimbursement to the Employer. The Available Amount, to the extent of any such refund, will be reinstated for the Period of Coverage in which the reimbursement was originally made.

In addition, if the Plan has made an erroneous or excess payment to any Participant or his Dependent, the Employer or Administrator will be entitled to recover such excess from the individual to whom such payment was made. The recovery of such overpayment may also be made by offsetting the amount of any other amount payable from the Plan by the amount of the overpayment under the Plan.

ARTICLE VII: AMENDMENT AND TERMINATION

7.01 RIGHT TO AMEND OR TERMINATE THE PLAN: This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer reserves the absolute right to amend or terminate the Plan at any time, and from time to time, in whole or in part, for any reason or for no reason.

No amendment shall change the terms and conditions of payment of any benefits to which Participants and covered Dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws. No termination shall eliminate any obligations of the Employer which therefore have arisen under the Plan. Any amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

An amendment to the Plan or resolution terminating the Plan may provide that benefits to any and all Participants will not continue beyond the date specified in such amendment or resolution, and if so provided, Participants will have no right to further benefits under the Plan. The Employer expressly reserves the right to amend or terminate the Plan in order to modify or eliminate any or all benefits provided to Employees and their Dependents.

7.02 SETTLOR FUNCTION: The Employer's decision to amend or terminate the Plan, in whole or in part, is not a fiduciary decision that must be made solely in the interest of Eligible Employees and their Dependents, but is a business decision that can be made solely in the Employer's interest.

ARTICLE VIII: MISCELLANEOUS PROVISIONS

8.01 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any Benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

8.02 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

8.03 NON-ASSIGNABILITY: The Plan shall not be liable for any debt, liability, contract, engagement or tort of any Participant or his Dependent, or beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

8.04 CONSTRUCTION:

(a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

(b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

8.05 CAPTIONS: The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan nor in any way will affect the Plan or the construction of any provision thereof.

8.06 GOVERNING LAW: The Plan is intended to qualify as a health reimbursement arrangement and is to be governed, construed, enforced, and administered in a manner consistent with the requirements of IRS Notice 2002-45. Nothing in the Plan will be construed as requiring compliance with Code provisions that do not otherwise apply.

To the extent the Employer determines that all or a portion of this Plan qualifies as a welfare benefit plan, as defined by Section (3)(1) of ERISA, the Plan shall be governed, construed, enforced, and administered in accordance with ERISA. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to any portion of this Plan that is exempt from the requirements of ERISA. Further, nothing in the Plan will be construed as requiring compliance with ERISA provisions that do not otherwise apply.

To the extent not preempted by federal law, the Plan will be governed, construed, enforced, and administered in accordance with the laws of the State identified in the Adoption Agreement.

8.07 PLAN NOT CONTRACT OF EMPLOYMENT: Nothing in the Plan will be deemed to constitute or create a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for employment of any Participant or Employee, or effect or modify the terms of an Employee's employment in any way. Nothing contained in the Plan will be deemed to give any Participant or Employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan. Furthermore, nothing in the Plan will be deemed to give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law.

8.08 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.