

# **HEALTH REIMBURSEMENT ARRANGEMENT**

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BASIC PLAN DOCUMENT

## HEALTH REIMBURSEMENT ARRANGEMENT

As used in this Plan, the following words and phrases shall have the meanings set forth herein unless a different meaning is clearly required by the context:

### ARTICLE I DEFINITIONS

- 1.1 “Administrator”** means the Employer or the person or persons designated by the Employer to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.
- 1.2 “Affiliated Employer”** means any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).
- 1.3 “Code”** means the Internal Revenue Code of 1986, as amended.
- 1.4 “Coverage Period”** means the time period as set forth in the Adoption Agreement.
- 1.5 “Dependent”** means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is an "alternate recipient" under a qualified medical child support order under ERISA Section 609 shall be considered a Dependent under this Arrangement.

Notwithstanding anything in the Plan to the contrary, a Participant's Child may remain on the Plan until the end of the calendar year in which the dependent attains age 26. A Participant's “Child” includes his natural child, and adopted child, or a child placed with the Employee for adoption. It may also include step children and/or foster children if elected on the Adoption Agreement. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- 1.6 “Effective Date”** means the date specified in the Adoption Agreement.
- 1.7 “Eligible Employee”** means any Eligible Employee as elected in the Adoption Agreement and as provided herein. An individual shall not be an “Eligible Employee” if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not “Eligible Employees” and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. Furthermore, Employees of an Affiliated Employer will not be treated as “Eligible Employees” prior to the date the Affiliated Employer adopts the Plan as a Participating Employer.

However, a self-employed individual as defined under Code Section 401(c) or a 2-percent shareholder as defined under Code Section 1372(b) shall not be eligible to participate in this Plan.

- 1.8 “Employee”** means any person who is employed by the Employer. The term “Employee” shall also include any person who is an employee of an Affiliated Employer and any Leased Employee deemed to be an Employee as provided in Code Section 414(n) or (o).
- 1.9 “Employer”** means the entity specified in the Adoption Agreement, any successor which shall maintain this Plan and any predecessor which has maintained this Plan. In addition, unless the context means otherwise, the term “Employer” shall include any Participating Employer which shall adopt this Plan.
- 1.10 “Employer Contribution”** means the amounts contributed to the Plan by the Employer.
- 1.11 “ERISA”** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- 1.12 “Leased Employee”** means, effective with respect to Plan Years beginning on or after January 1, 1997, any person (other than an Employee of the recipient Employer) who, pursuant to an agreement between the recipient Employer and any other person or entity (“leasing organization”), has performed services for the recipient (or for the recipient and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, and such services are performed under primary direction or control by the recipient Employer. Contributions or benefits provided a Leased Employee by the leasing organization which are

attributable to services performed for the recipient Employer shall be treated as provided by the recipient Employer. Furthermore, Compensation for a Leased Employee shall only include Compensation from the leasing organization that is attributable to services performed for the recipient Employer.

A Leased Employee shall not be considered an employee of the recipient Employer if: (a) such employee is covered by a money purchase pension plan providing: (1) a nonintegrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), but for Plan Years beginning prior to January 1, 1998, including amounts contributed pursuant to a salary reduction agreement which are excludable from the employee's gross income under Code Sections 125, 402(e)(3), 402(h)(1)(B), 403(b), or for Plan Years beginning on or after January 1, 2001 (or as of a date, no earlier than January 1, 1998, as specified in an addendum to the Adoption Agreement), 132(f)(4), (2) immediate participation, and (3) full and immediate vesting; and (b) leased employees do not constitute more than twenty percent (20%) of the recipient Employer's nonhighly compensated workforce.

- 1.13 "Participant"** means any Eligible Employee who has satisfied the requirements of Section 2.1 and has not for any reason become ineligible to participate further in the Plan.
- 1.14 "Plan"** means this Basic Plan Document and the Adoption Agreement as adopted by the Employer, including all amendments thereto. "Plan" means the "Health Reimbursement Arrangement."
- 1.15 "Premiums"** mean the Participant's cost for any health plan coverage.
- 1.16 "Qualifying Medical Expenses"** means any expense eligible for reimbursement under the Health Reimbursement Arrangement which would qualify as a "medical expense" (within the meaning of Code Section 213(d) and as allowed under Code Sections 105 and 106 and the rulings and Treasury regulations thereunder) of the Participant, the Participant's spouse or a Dependent and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage, including a health Flexible Spending Account. Qualifying Medical Expenses covered by this Plan are limited as elected in the Adoption Agreement. Effective January 1, 2011, notwithstanding anything in this Arrangement to the contrary, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" as defined in Code Section 106(f) or is not insulin. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c). If the Employer provides Health Savings Accounts for Participants, Qualifying Medical Expenses reimbursed shall be limited to those allowed under Code Section 223. "Incurred" means when the Participant is provided with the medical care that gives rise to the Qualifying Medical Expense and not when the Participant formally billed or charged for, or pays for, the medical care.

## ARTICLE II

## **PARTICIPATION**

### **2.1 Eligibility**

Any Eligible Employee shall be eligible to participate hereunder on the date such Employee satisfies the conditions of eligibility elected in the Adoption Agreement.

An Eligible Employee may make or change an election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

### **2.2 Effective Date of Participation**

An Eligible Employee who has satisfied the conditions of eligibility pursuant to Section 2.1 shall become a Participant effective as of the date elected in the Adoption Agreement.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise have become a Participant, shall go from a classification of a noneligible Employee to an Eligible Employee, such Employee shall become a Participant on the date such Employee becomes an Eligible Employee or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise become a Participant, shall go from a classification of an Eligible Employee to a noneligible class of Employees, such Employee shall become a Participant in the Plan on the date such Employee again becomes an Eligible Employee, or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

### **2.3 Termination of Participation**

This Section shall be applied and administered consistent with any rights a Participant and the Participant's Dependents may be entitled to pursuant to Code Section 4980B, Section 7.13 of the Plan, or any election on the Adoption Agreement. In the case of the death of the Participant, any remaining balances may only be paid out as reimbursements for Qualifying Medical Expenses of the Participant, his or her spouse and/or his or her dependent, and shall not constitute a death benefit to the Participant's estate and/or the Participant's beneficiaries.

## **ARTICLE III**

## **BENEFITS**

### **3.1 Establishment of Plan**

- (a) This Health Reimbursement Arrangement is intended to qualify as a Health Reimbursement Arrangement under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.
- (b) Participants in this Health Reimbursement Arrangement may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the Plan and the Adoption Agreement. Unless otherwise elected in the Adoption Agreement, this Plan shall reimburse any expenses only after amounts in all other Plans that could reimburse the expense have been exhausted.
- (c) The Employer shall make available to each Participant an Employer Contribution as elected in the Adoption Agreement, for the reimbursement of Qualifying Medical Expenses. No salary reductions may be made to this Health Reimbursement Arrangement.
- (d) This Plan shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder, to the extent necessary to maintain this Plan as a Health Reimbursement Arrangement.
- (e) If the Employer maintains Health Savings Accounts for Participants, this Arrangement shall be operated in accordance with the restrictions under Code Section 223.

### **3.2 Nondiscrimination Requirements**

- (a) It is the intent of this Health Reimbursement Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.
- (b) If the Administrator deems it necessary to avoid discrimination under this Health Reimbursement Arrangement, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

### **3.3 Health Reimbursement Arrangement Claims**

- (a) The Administrator shall direct the reimbursement to each eligible Participant for all Qualifying Medical Expenses. All Qualifying Medical Expenses eligible for reimbursement pursuant to Section 3.1(b) shall be reimbursed during the Coverage Period, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred during a Coverage Period. Claims must include receipts or

documentation that the expense being incurred is eligible for reimbursement, in order to claim reimbursement. Expenses may be reimbursed in subsequent Coverage Period, subject to the provisions of Number 21 on the Adoption Agreement and Section 3.3(c) below. However, a Participant may not submit claims incurred prior to beginning participation in the Plan and/or the Effective Date of the Plan, whichever is earlier.

- (b) Notwithstanding the foregoing, if elected in the Adoption Agreement, Qualifying Medical Expenses shall not be reimbursable under this Plan if eligible for reimbursement and claimed under the Employer's Health Flexible Spending Account or Health Savings Account, if applicable.
- (c) Claims for the reimbursement of Qualifying Medical Expenses incurred in any Coverage Period shall be paid as soon after a claim has been filed as is administratively practicable. However, if a Participant fails to submit a claim within the period elected at Question 21 on the Adoption Agreement immediately following the end of the Coverage Period or calendar year, as selected, those Medical Expense claims shall not be considered for reimbursement by the Administrator.
- (d) Reimbursement payments under this Plan shall be made directly to the Participant.
- (e) If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, such remainder shall be carried forward to another Coverage Period or forfeited, as elected in the Adoption Agreement.

### **3.4 Debit and Credit Cards**

- (a) Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Qualifying Medical Expenses, subject to the following terms:
- (b) Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
- (c) Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Coverage Period the Participant remains a Participant in the Health Reimbursement Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant withdraws from the Health Reimbursement Arrangement.
- (d) The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth on the Adoption Agreement.

- (e) The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
- (f) The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:
  - (i) Co-payments for doctor and other medical care;
  - (ii) Purchase of drugs obtained with a prescription;
  - (iii) Purchase of medical items such as eyeglasses, syringes, insulin, crutches, etc.
- (g) Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.
- (h) If such purchase is later determined by the Administrator to not to qualify as a Qualifying Medical Expense, the Administrator, in its discretion, shall use the one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator 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.
  - (i) Repayment of the improper amount by the Participant;
  - (ii) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
  - (iii) Claims substitution or offset of future claims until the amount is repaid.
  - (iv) if subsections (i) through (iii) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

### **3.5 Qualified HSA Distributions**

- (a) **Qualified HSA Distributions.** If elected in the Adoption Agreement, a Participant may request a one-time Qualified HSA Distribution of amounts remaining in the Health Reimbursement Arrangement in the Plan as of the last day of the Plan Year selected. The maximum distribution that may be requested is the lesser of the amount in the Participant's Account as of September 21, 2006, or the end of the Plan Year for which the distribution is being requested. "Qualified HSA Distribution" means a direct distribution of an amount from the Health Reimbursement Arrangement to the Participant's Health Savings Account. A Qualified HSA Distribution must be contributed directly to the Health Savings



Account trustee or custodian. Qualified HSA Distributions are not taken into account in applying the annual limit for Health Savings Account contributions.

- (b) Conditions: The following conditions apply:
- (i) The Participant requesting the distribution must have been employed by the Employer on September 21, 2006;
  - (ii) Any Qualified HSA Distribution must be directly transferred to the Participant's Health Savings Account by the fifteenth day of the third calendar month following the end of the Plan Year and cannot be requested in cash;
  - (iii) The Qualified HSA Distribution must be elected by the last day of a Plan Year;
  - (iv) After the Qualified HSA Distribution is made, a Participant's balance in the Plan shall be zero. The amount of the Qualified HSA Distribution is determined on a "cash basis." "Cash basis" means the balance as of any date, without taking into account expenses incurred that have not been reimbursed as of that date. Pending claims, claims submitted, claims received or claims under review that have not been paid as of a date are not taken into account for purposes of determining the account balance as of that date. The balance as of any date of the Health Reimbursement Arrangement is determined by applying the uniform coverage rule (i.e., maximum reimbursement available for the Plan Year reduced for prior reimbursements paid as of the date for the same Plan Year).
  - (v) The Qualified HSA Distribution option must be offered to all Employees who are covered by the Employer's high deductible health plan.

#### **ARTICLE IV ERISA PROVISIONS**

##### **4.1 Claim for Benefits**

Any claim for Benefits shall be made to the Administrator. The following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the claim determination;

- (2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

#### **4.2 Named Fiduciary**

The “named Fiduciaries” of this Plan are (1) the Employer and (2) the Administrator. The named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocating or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole responsibility for providing benefits under the Plan; and shall have the sole authority to appoint and remove the Administrator; and to amend the elective provisions of the Adoption Agreement or terminate, in whole or in part, the Plan. The Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each named Fiduciary may rely upon any such direction, information or action of another named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

#### **4.3 General Fiduciary Responsibilities**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan; with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and in accordance with

the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

#### **4.4 Nonassignability of Rights**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

### **ARTICLE V ADMINISTRATION**

#### **5.1 Plan Administration**

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

- (a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;
- (d) To limit benefits for certain highly compensated individuals if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- (e) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the

Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

- (f) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.
- (g) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.
- (h) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan; and
- (i) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 105(h) and the Treasury regulations thereunder.

## **5.2 Examination of Records**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

## **5.3 Indemnification of Administrator**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## **5.4 Coordination of Benefits**

When a Participant is covered by this Plan and another plan, or the Participant's Spouse is covered by this Plan and by another plan or the Participant's dependents are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the allowable Qualified Medical Expenses.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid (non-duplication of benefits). The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Participant.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
  - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
  - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired

Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (e) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
  - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
  - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (f) When a child's parents are divorced or legally separated, these rules will apply:
  - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
  - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
  - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
  - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans

covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

- (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from an insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant will give this Plan the information it asks for about other plans and their payment of Qualified Medical Expenses.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Participant and his or her dependents. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.



Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Participant and his or her dependents under the Plan.

## **5.5 Right of Subrogation and Refund**

When this provision applies. The Participant and his or her dependents may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Participant and his or her dependents may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Participant and his or her dependents may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Participant and his or her dependents has against any Third Party, or insurer, whether or not the Participant and his or her dependents chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Participant and his or her dependents whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Participant and his or her dependents under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Participant and his or her dependents as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Participant and his or her dependents, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Participant and his or her dependents to the payments of those benefits.

The Participant and his or her dependents:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Participant and his or her dependents agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Participant and his or her dependents relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Participant and his or her dependents may have to recover payments from any responsible

third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Participant and his or her dependents' Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from the Participant and his or her dependents. Also, the Plan's right to Subrogation still applies if the Recovery received by the Participant and his or her dependents is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Participant and his or her dependents will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Participant and his or her dependents will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Participant and his or her dependents if a Participant and his or her dependents refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Participant and his or her dependents is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Participant and his or her dependents or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Participant and his or her dependents by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Participant and his or her dependents' claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Participant and his or her dependents is covered. This right of Refund also applies when a Participant and his or her dependents recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

## **ARTICLE VI AMENDMENT OR TERMINATION OF PLAN**

### **6.1 Amendment**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant.

### **6.2 Termination**

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further reimbursements shall be made.

## **ARTICLE VII MISCELLANEOUS**

### **7.1 Plan Interpretation**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 7.11.

### **7.2 Gender and Number**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

### **7.3 Written Document**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 105 and any Treasury regulations thereunder.

#### **7.4 Exclusive Benefit**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

#### **7.5 Participant's Rights**

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

#### **7.6 Action by the Employer**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

#### **7.7 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 under the Plan will be excludable from the Participant'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. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

#### **7.8 Indemnification of Employer by Participants**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Medical Expense such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

## **7.9 Funding**

Unless otherwise required by law, amounts made available by the Employer need not be placed in trust, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or 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 the Plan may be made.

## **7.10 Governing Law**

This Plan and Trust shall be construed and enforced according to the Code, ERISA, and the laws of the state or commonwealth in which the Employer's principal office is located (unless otherwise designated in the Adoption Agreement), other than its laws respecting choice of law, to the extent not pre-empted by ERISA.

## **7.11 Severability**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

## **7.12 Headings**

The headings and subheadings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

## **7.13 Continuation of Coverage**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

## **7.14 Family and Medical Leave Act**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

## **7.15 Health Insurance Portability and Accountability Act**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

## **7.16 Uniformed Services Employment and Reemployment Rights Act**

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

## **7.17 HIPAA Privacy Standards**

- (a) If this Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the “Privacy Standards”), then this Section shall apply.
- (b) The Plan shall not disclose Protected Health Information to any member of Employer’s workforce unless each of the conditions set out in this Section are met. “Protected Health Information” shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (c) Protected Health Information disclosed to members of Employer’s workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan’s administrative functions shall include all Plan payment functions and health care operations. The terms “payment” and “health care operations” shall have the same definitions as set out in the Privacy Standards, but the term “payment” generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.
- (d) The Plan shall disclose Protected Health Information only to members of the Employer’s workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. “Members of the Employer’s workforce” shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.
  - (1) An authorized member of the Employer’s workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (2) In the event that any member of the Employer’s workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan’s privacy officer. The privacy officer shall take appropriate action, including:

- (i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
  - (ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
  - (iii) mitigation of any harm caused by the breach, to the extent practicable; and
  - (iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (e) The Employer must provide certification to the Plan that it agrees to:
  - (1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
  - (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
  - (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  - (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information 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 purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

#### **7.18 HIPAA Electronic Security Standards**

If this Plan is subject to the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), then this Section shall apply as follows:

- (a) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 7.17.
- (d) The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (e) Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative



functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

- (f) The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.
  - (1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:
    - (i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
    - (ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
    - (iii) mitigation of any harm caused by the breach, to the extent practicable; and
    - (iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

- (g) The Employer must provide certification to the Plan that it agrees to:
- (1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
  - (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
  - (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  - (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
  - (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
  - (9) If feasible, return or destroy all Protected Health Information 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 purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
  - (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

**7.19 Mental Health Parity and Addiction Equity Act**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

**7.20 Genetic Information Nondiscrimination Act (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

**7.21 Women's Health and Cancer Rights Act**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

**7.22 Newborns' and Mothers' Health Protection Act**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

**CERTIFICATE OF ADOPTING RESOLUTION**

The undersigned Principal of \_\_\_\_\_ (the Employer) hereby certifies that the following resolutions were duly adopted by the board on \_\_\_\_\_, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the Health Reimbursement Arrangement effective \_\_\_\_\_, presented to this meeting is hereby approved and adopted and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

The undersigned further certifies that attached hereto is a true copy of the Health Reimbursement Arrangement and the Summary Plan Description approved and adopted in the foregoing resolutions.

\_\_\_\_\_  
Principal

\_\_\_\_\_  
Date