HEALTH REIMBURSEMENT PLAN
BASIC PLAN DOCUMENT

TABLE OF CONTENTS

ARTICLE 1 INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a health reimbursement arrangement that provides benefits that are excludable from gross income under Code section 105(b).

To the extent provided in the Adoption Agreement, the Plan provides a health reimbursement arrangement that is integrated with another group health plan (as described in 26 C.F.R. 54.9815-2711(d)(1)), a health reimbursement arrangement that is not integrated with another group health plan, or a qualified small employer health reimbursement arrangement (QSEHRA).

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Persons of the Employer on or after the Effective Date, and the rights and benefits, if any, of former Employees whose employment terminated prior to the Effective Date shall be determined under the provisions of the Plan, as in effect prior to that date.

ARTICLE 2 DEFINITIONS

Account means
the bookkeeping balance of an account established for each Participant as of the applicable date. The term "Account" or "Accounts" shall include account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Active Employee means
an individual who is currently an Employee of an Employer, including an Employee who is on an approved leave of absence.

Adoption Agreement means
the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

Affiliate means
any employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Affordable Care Act means
The Patient Protection and Affordable Care Act of 2010, as amended.

Applicable Large Employer means
an employer described in Code section 4980H(c)(2).

COBRA means
the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means
the Internal Revenue Code of 1986, as amended.

Compensation means
the cash wages or salary paid to a Participant.

Covered Person means
an individual whose medical expenses are eligible for reimbursement under the Plan.

Dependent means
an individual who qualifies as a dependent or child whose expenses are eligible for reimbursement under Code section 105(b). To the extent applicable, a child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section

609 shall be considered a Dependent under this Plan.

Effective Date means
The date set forth in Part A of the Adoption Agreement, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee or Eligible Person means
an Employee or former Employee who is eligible to participate in the Plan, subject to the modifications and exclusions described herein and in the Adoption Agreement.

Eligible Expenses means
the expenses eligible for reimbursement by the Plan, as described in the Adoption Agreement.

Employee means
any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

Employer means
the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

Entry Date means
the date set forth in the Adoption Agreement on which an Eligible Person becomes covered as a Participant under the Plan.

ERISA means
the Employee Retirement Income Security Act of 1974, as amended.

FMLA means
the Family and Medical Leave Act of 1993 as amended.

Health Flexible Spending Account or Health FSA means
a health flexible spending account established and maintained by the Employer under Code section 125.

Health Reimbursement Arrangement or HRA means
the health reimbursement arrangement (including a qualified small employer health reimbursement arrangement) established under the Plan pursuant to Article 3, 4, or 5, as applicable.

HIPAA means
the Health Insurance Portability and Accountability Act of 1996, as amended.

Integrated HRA means
an HRA that is integrated with Qualified Health Coverage and is established pursuant to Article 3.

Participant means
an Eligible Person who participates in the Plan in accordance with Articles 3, 4 or 5, as applicable.

Period of Coverage means
the Plan Year or other period of coverage described in Part A of the Adoption Agreement.

Plan means

the plan as identified in Part A.2 of the Adoption Agreement and as described in this Basic Plan Document and Adoption Agreement.

Plan Administrator means
the person(s) designated pursuant to the Adoption Agreement and Section 14.01.

Plan Sponsor means
the entity described in the Adoption Agreement and any successor entity that maintains the Plan.

Plan Year means
The 12-month period identified in Part A of the Adoption Agreement.

Qualified Small Employer Health Reimbursement Arrangement or QSEHRA means
a qualified small employer health reimbursement arrangement established under the Plan pursuant to Article 5.

Qualified Health Coverage means
a group health plan that is not a health reimbursement arrangement or other account-based plan that does not consist solely of excepted benefits, coverage under Part B or Part D of Title XVIII of the Social Security Act (Medicare), or coverage under TRICARE.

Stand-Alone HRA means
an HRA that is not integrated with a Qualified Health Plan and is established under the Plan pursuant to Article 4.

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3 INTEGRATED HRA

Section 3.01 IN GENERAL

To the extent that the Adoption Agreement provides, this Plan is intended to be an Integrated HRA as described in 26 CFR section 54.9815-2711(d)(1)and is intended to satisfy one of the integration methods under 26 CFR sections 54.9815-2711(d)(2) and 54.9815-2711(d)(5), and shall be interpreted in a manner consistent with such regulations.

Section 3.02 ELIGIBLE PERSONS

An Eligible Person is an Employee (or former Employee) who meets the requirements set forth in the Adoption Agreement, who is not excluded pursuant to Section 3.03, and who is enrolled in Qualified Health Coverage.

Individuals who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date.

Section 3.03 INELIGIBLE PERSONS

Notwithstanding anything herein to the contrary, individuals who are not identified in the Adoption Agreement as Eligible Employees or who are identified as excluded from the Plan may not participate in the Plan. Employees (including former Employees) who are not enrolled in Qualified Health Coverage are not eligible to participate in the Integrated HRA.

Section 3.04 PARTICIPATION

(a) *Participation.* An Eligible Person will become a Participant in the Integrated HRA on the Entry Date set forth in the Adoption Agreement, but no earlier than the date the Eligible Person is enrolled in Qualified Health Coverage.

(b) *Opt Out.* An Eligible Person may elect to permanently opt out of and waive future reimbursements from the Integrated HRA. The opportunity to make such election shall occur once per year (or more frequently as the Plan Administrator determines). Any such opt-out must be made in writing on a form prescribed by the Plan Administrator. If a Participant elects to permanently opt out of the Plan, the Participant will not receive any further Plan reimbursement for expenses incurred after the effective date of the opt-out.

(c) *Termination of Participation.* Except as otherwise provided in the Adoption Agreement, participation in the Plan will terminate on the date the Participant is no longer an Eligible Person.

(d) *Resumption of Participation.* Except as otherwise provided in the Adoption Agreement, an individual who loses coverage under Section 3.04(c) shall resume participation in the Plan on the first Entry Date following (or coincident with, as applicable) the date he or she again becomes an Eligible Employee, provided the individual is enrolled in Qualified Health Coverage.

Section 3.05 BENEFITS

(a) *Integrated HRA Benefit.* A Participant shall receive the Integrated HRA benefits described herein, subject to the provisions of the Adoption Agreement.
   (1) *HRA Limit.* If selected in the Adoption Agreement, the Integrated HRA will reimburse Eligible Expenses up to the amount specified in the Adoption Agreement.
   (2) *HRA Threshold.* If selected in the Adoption Agreement, the Integrated HRA will reimburse Eligible Expenses incurred after the Covered Person has met the threshold specified in the Adoption Agreement, and up to the amount specified in the Adoption Agreement.
   (3) *Partial Reimbursement.* If selected in the Adoption Agreement, the Integrated HRA will reimburse a portion of the Eligible Expenses up to the amount specified in the Adoption Agreement.
   (4) *Account-Based HRA.* If selected in the Adoption Agreement, the Participant's Integrated HRA will be credited with an amount specified in the Adoption Agreement, which can be used to reimburse Eligible Expenses to the extent specified in the Adoption Agreement.

   Expenses incurred in excess of the limits specified in the Adoption Agreement are not payable by the Integrated HRA.

(b) *No Participant Contributions.* Participants shall not contribute to the Integrated HRA, except as provided in Section 10.06.

(c) *Carryover.* To the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Period of Coverage unused benefits under a Participant's Integrated HRA as of the end of the Period of Coverage. Except as otherwise provided in the Adoption Agreement, the benefit remaining unused as of the end of the Period of Coverage is determined after all Eligible Expenses have been reimbursed and the claims deadline for the Period of Coverage has passed. The carryover amount will be used to increase the HRA reimbursement limit or the amount credited to an account-based HRA, as applicable. Any unused benefit remaining in the Integrated HRA in excess of the benefit carried over as specified in the Adoption Agreement will be forfeited in accordance with Section 3.09. The carryover benefit may be used to pay or reimburse Eligible Expenses incurred during the Period of Coverage specified in the Adoption Agreement. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Period of Coverage, provided that any such procedure is non-discriminatory.

Section 3.06 ELIGIBLE EXPENSES

(a) *Eligible Expenses.* A Participant may be reimbursed from the Integrated HRA for the Eligible Expenses specified in the Adoption Agreement, provided that such expenses are not covered, paid, or reimbursed from any other source.

(b) For purposes of determining whether an expense is eligible for reimbursement by the Integrated HRA as an Eligible Expense, the following applies:
   (1) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.
   (2) *Long-Term Care Expenses.* Notwithstanding anything herein to the contrary, long-term care expenses shall not be Eligible Expenses if they are incurred by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner and the maximum amount of reimbursement reasonably available to a Participant for coverage under the Integrated HRA is less than 500% of the value of the coverage.

(c) *Ineligible Expenses.* Expenses incurred by individuals who are not enrolled in Qualified Health Coverage, or who are not covered by this Plan when the expense is incurred, are not eligible for reimbursement under the Plan.

Section 3.07 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from the Plan of Eligible Expenses incurred during the Period of Coverage, except as otherwise provided herein and in the Adoption Agreement.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement under the Plan during the Period of Coverage and no later than the date specified in the Adoption Agreement. The claim for reimbursement must be made in a manner acceptable to the Plan Administrator and must include such proof of claim that substantiates the Eligible Expense as the Plan Administrator deems satisfactory.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Integrated HRA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the Integrated HRA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with Health Flexible Spending Accounts.* Except as otherwise provided in the Adoption Agreement, reimbursement under the Integrated HRA is only available after expenses exceeding the applicable dollar amounts in the Participant's Health FSA have been paid.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who is enrolled in the Employer group health plan may elect that any eligible expenses that are not covered under the Employer's group health plan, such as co-payments, co-insurance or deductibles, be automatically paid through the Integrated HRA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of Eligible Expenses.

Section 3.08 SUSPENSION OF INTEGRATED HRA

To the extent provided in the Adoption Agreement, Participant may elect, prior to the commencement of the Period of Coverage, to forgo the payment or reimbursement of Eligible Expenses incurred during such Period of Coverage. Any such suspension shall be made in writing in a form prescribed by the Plan Administrator. Such suspension will remain effective for the entire Period of Coverage and cannot be revoked during the Period of Coverage. Eligible Expenses incurred prior to the suspended Period of Coverage may be reimbursed during the suspended period. Expenses incurred during the period during which the HRA is suspended (other than certain Eligible Expenses otherwise allowed to be paid or reimbursed by an HRA as set forth in the Adoption Agreement, referred to herein as "Allowed Expenses"), cannot be paid or reimbursed by the HRA (including after the HRA suspension ends). However, the Employer may continue to make contributions to the Integrated HRA during the suspension period and thus the maximum available amount under the Integrated HRA is not affected by the suspension but is available for the payment or reimbursement of Allowed Expenses incurred during the suspension period as well as Eligible Expenses incurred in later Periods of Coverage.

Section 3.09 FORFEITURE

Any Integrated HRA benefit that remains unused at the end of any Period of Coverage that is not carried over in accordance with Section 3.05(c) (if applicable) shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the timeframe provided in the Adoption Agreement.

Section 3.10 TERMINATION OF COVERAGE

(a) *Termination of Covered Person Status.* Unless provided otherwise in the Adoption Agreement, participation by a Covered Person in the Integrated HRA shall cease upon the date the individual fails to qualify as a Covered Person and, in such case, expenses incurred after the date the individual fails to qualify as a Covered Person are not eligible for reimbursement by the Integrated HRA.

(b) *Termination of Integration.* In the event the Integrated HRA ceases to be integrated with Qualified Health Coverage as required by applicable law (including where the Participant is no longer enrolled in Qualified Health Coverage), the Plan will reimburse Eligible Expenses incurred on and prior to the date in which the HRA ceased to be integrated with the with Qualified Health Coverage, except as otherwise provided in the Adoption Agreement.

(c) *Unused Amounts.* Notwithstanding the foregoing and to the extent provided in the Adoption Agreement, unused amounts that were

credited to an Integrated HRA may be used to reimburse Eligible Expenses in accordance with Article 3 after a Participant or other Covered Person ceases to be covered by other Qualified Health Coverage.

(d) *Permanent Opt-Out.* An Eligible Employee may elect to permanently opt out of and waive future reimbursements from the Plan upon termination of employment. Any such opt-out must be made in writing on a form prescribed by the Plan Administrator. If a Participant elects to permanently opt out of the Plan, the Participant will not receive any reimbursement for expenses incurred after the effective date of the opt-out.

ARTICLE 4 STAND ALONE HRA

Section 4.01 IN GENERAL

To the extent that the Adoption Agreement provides, this Plan is intended to be a Stand-Alone HRA that is not an Integrated HRA under Article 3 or a QSEHRA under Article 5.

Section 4.02 ELIGIBLE PERSONS

An Eligible Person is an Employee or former Employee who meets the requirements set forth in the Adoption Agreement and who is not excluded pursuant to Section 4.03.

Individuals who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date.

Section 4.03 INELIGIBLE PERSONS

Notwithstanding anything herein to the contrary, individuals who are not identified in the Adoption Agreement as Eligible Employees or who are identified as excluded from the Plan may not participate in the Plan.

Section 4.04 PARTICIPATION

(a) *Participation.* An Eligible Person will become a Participant in the Stand Alone HRA on the Entry Date set forth in the Adoption Agreement.

(b) *Opt Out.* An Eligible Person may elect to permanently opt out of and waive future reimbursements from the Stand Alone HRA once per year (or more frequently as the Plan Administrator determines). Any such opt-out must be made in writing on a form prescribed by the Plan Administrator. If a Participant elects to permanently opt out of the Plan, the Participant will not receive any further Plan reimbursement for expenses incurred after the effective date of the opt-out.

(c) *Termination of Participation.* Except as otherwise provided in the Adoption Agreement, participation in the Plan will terminate on the date the Participant is no longer an Eligible Person.

(d) *Resumption of Participation.* Except as otherwise provided in the Adoption Agreement, an individual who loses coverage under Section 4.04(c) shall resume participation in the Plan on the first Entry Date following (or coincident with, as applicable) the date he or she again becomes an Eligible Person.

Section 4.05 BENEFITS

(a) *Stand Alone HRA Benefit.* A Participant shall receive the Stand Alone HRA benefits described herein, subject to the provisions of the Adoption Agreement.
   (1) *HRA Limit.* If selected in the Adoption Agreement, the Stand Alone HRA will reimburse Eligible Expenses up to the amount specified in the Adoption Agreement.
   (2) *HRA Threshold.* If selected in the Adoption Agreement, the Stand Alone HRA will reimburse Eligible Expenses incurred after the Covered Person has met the threshold specified in the Adoption Agreement, and up to the amount specified in the Adoption Agreement.
   (3) *Partial Reimbursement.* If selected in the Adoption Agreement, the Stand Alone HRA will reimburse a portion of the Eligible Expenses up to the amount specified in the Adoption Agreement.

(4) *Account-Based HRA.* If selected in the Adoption Agreement, the Participant's Stand Alone HRA will be credited with an amount specified in the Adoption Agreement, which can be used to reimburse Eligible Expenses to the extent specified in the Adoption Agreement.

Expenses incurred in excess of the limits specified in the Adoption Agreement are not payable by the Stand Alone HRA.

(b) *No Participant Contributions.* Participants shall not contribute to the Stand Alone HRA, except as provided in Section 10.06.

(c) *Carryover.* To the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Period of Coverage unused benefits under a Participant's Stand Alone HRA as of the end of the Period of Coverage. Except as otherwise provided in the Adoption Agreement, the benefit remaining unused as of the end of the Period of Coverage is determined after all Eligible Expenses have been reimbursed and the claims deadline for the Period of Coverage has passed. The carryover amount will be used to increase the HRA reimbursement limit or the amount credited to an account-based HRA, as applicable. Any unused benefit remaining in the Stand Alone HRA in excess of the benefit carried over as specified in the Adoption Agreement, if any, will be forfeited in accordance with Section 4.09. The carryover benefit may be used to pay or reimburse Eligible Expenses incurred during the Period of Coverage specified in the Adoption Agreement. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Period of Coverage, provided that any such procedure is non-discriminatory.

Section 4.06 ELIGIBLE EXPENSES

(a) *Eligible Expenses.* A Participant may be reimbursed from a Stand Alone HRA for the Eligible Expenses specified in the Adoption Agreement, provided that such expenses are not covered, paid, or reimbursed from any other source.

(b) For purposes of determining whether an expense is eligible for reimbursement by the Stand Alone HRA as an Eligible Expense, the following applies:

(1) *Coverage of Adult Children.* To the extent provided in the Adoption Agreement, expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

(2) *Long-Term Care Expenses.* Notwithstanding anything herein to the contrary, long-term care expenses shall not be Eligible Expenses if they are incurred by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner and the maximum amount of reimbursement reasonably available to a Participant for coverage under the Stand Alone HRA is less than 500% of the value of the coverage.

(c) *Ineligible Expenses.* Expenses incurred by individuals who are not covered by this Plan when the expense is incurred are not eligible for reimbursement under the Plan.

Section 4.07 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from the Plan of Eligible Expenses incurred during the Period of Coverage, except as otherwise provided herein and in the Adoption Agreement.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement under the Plan during the Period of Coverage and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Stand Alone HRA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the Stand Alone HRA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with Health Flexible Spending Accounts.* Reimbursement under the Stand Alone HRA shall be coordinated with a Participant's Health FSA, if applicable, as set forth in the Adoption Agreement.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who is enrolled in an Employer's group health plan may elect

that any eligible expenses that are not covered under the Employer's group health plan, such as co-payments, co-insurance or deductibles, be automatically paid through the Stand Alone HRA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of Eligible Expenses.

Section 4.08 SUSPENSION OF STAND ALONE HRA

To the extent provided in the Adoption Agreement, Participant may elect, prior to the commencement of the Period of Coverage, to forgo the payment or reimbursement of Eligible Expenses incurred during such Period of Coverage. Any such suspension shall be made in writing in a form prescribed by the Plan Administrator. Such suspension will remain effective for the entire Period of Coverage and cannot be revoked during the Period of Coverage. Eligible Expenses incurred prior to the suspended Period of Coverage may be reimbursed during the suspended period. Expenses incurred during which the HRA is suspended (other than certain Eligible Expenses otherwise allowed to be paid or reimbursed by an HRA as set forth in the Adoption Agreement, referred to herein as "Allowed Expenses"), cannot be paid or reimbursed by the HRA (including after the HRA suspension ends). However, the Employer may continue to make contributions to the Stand Alone HRA during the suspension period and thus the maximum available amount under the Stand Alone HRA is not affected by the suspension but is available for the payment or reimbursement of Allowed Expenses incurred during the suspension period as well as Eligible Expenses incurred in later Periods of Coverage.

Section 4.09 FORFEITURE

Any Stand Alone HRA benefit that remains unused at the end of any Period of Coverage that is not carried over in accordance with Section 4.05(c) (if applicable) shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the timeframe provided in the Adoption Agreement.

Section 4.10 TERMINATION OF COVERAGE

(a) Except as provided in the Adoption Agreement, participation by a Covered Person in the Stand Alone HRA shall cease upon the date the individual fails to qualify as Covered Person and, in such case, expenses incurred after the date the individual fails to qualify as Covered Person are not eligible for reimbursement by the Stand Alone HSA.

(b) *Permanent Opt-Out.* An Eligible Employee may elect to permanently opt out of and waive future reimbursements from the Plan upon termination of employment. Any such opt-out must be made in writing on a form prescribed by the Plan Administrator. If a Participant elects to permanently opt out of the Plan, the Participant will not receive any reimbursement for expenses incurred after the effective date of the opt-out.

ARTICLE 5 QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGMENT (QSEHRA)

Section 5.01 IN GENERAL

This Article 5 shall apply only to plans using the QSEHRA Adoption Agreement, this Plan is intended to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) within the meaning of Code section 9831(d)(2) and shall be interpreted in a manner consistent with such Code sections applicable to QSEHRAs and applicable guidance (including IRS Notice 2017-67 and any superseding guidance).

The Employer is not an Applicable Large Employer and does not offer a group health plan to any of its employees (including, but not limited to, reimbursements under a health flexible spending account, any other health reimbursement arrangement, or a plan that provides only excepted benefits). The Employer is not a member of a group of employers treated as a single employer under Code sections 414(b), (c), (m), or (o) in which any other member offers a group health plan.

Section 5.02 ELIGIBLE EMPLOYEES

An Eligible Employee is an Active Employee of the Employer or any Affiliate who is identified in the Adoption Agreement as an Eligible Employee and who is not excluded pursuant to Section 5.03.

Individuals who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date.

Section 5.03 INELIGIBLE PERSONS

Notwithstanding anything herein to the contrary, the individuals identified in the Adoption Agreement as excluded employees are not Eligible Employees and may not participate in the Plan. Former Employees, 2% shareholders who are otherwise employees, and non-employee owners are not eligible to participate in the QSEHRA.

Section 5.04 PARTICIPATION

(a) *Participation.* An Eligible Employee will become a Participant in the Plan on the Entry Date set forth in the Adoption Agreement.

(b) *Notice.* The Plan Administrator shall provide each Eligible Employee with a written notice in accordance with Code section 9831(d)(4) at least 90 days before the beginning of each Plan Year or, for an Employee who is not eligible to participate at the beginning of the Plan Year, the date on which the Employee is first eligible to participate in the Plan.

(c) *Termination of Participation.* Participation in the Plan will terminate on the date the Participant is no longer an Eligible Employee.

(d) *Resumption of Participation.* An individual who loses coverage under Section 5.04(c) shall resume participation in the Plan on the Entry Date set forth in the Adoption Agreement.

Section 5.05 BENEFITS

(a) *QSEHRA Benefit.* A Participant shall receive the QSEHRA benefits described herein, subject to the provisions of the Adoption Agreement.
   (1) *HRA Limit.* If selected in the Adoption Agreement, the QSEHRA will reimburse Eligible Expenses up to the amount specified in the Adoption Agreement.
   (2) *Partial Reimbursement.* If selected in the Adoption Agreement, the QSEHRA will reimburse a portion of the Eligible Expenses up to the amount specified in the Adoption Agreement.
   (3) *Account-Based QSEHRA.* If selected in the Adoption Agreement, the Participant's QSEHRA will be credited with an amount specified in the Adoption Agreement, which can be used to reimburse Eligible Expenses to the extent specified in the Adoption Agreement.
   (4) *Employees in the Same Family.* A Participant's QSEHRA benefit under the Plan shall not be reduced solely because they are covered under the same health insurance as another Employee, or are related to another Participant.

   Expenses incurred in excess of the limits specified herein and in the Adoption Agreement are not payable by the QSEHRA.

(b) *Maximum Benefit.* Notwithstanding anything herein or in the Adoption Agreement to the contrary, the amount that the QSEHRA shall reimburse for any calendar year shall not exceed the maximum amount permitted by Code sections 9831(d)(2)(B)(iii) and 9831(d)(2)(D).

(c) *No Participant Contributions.* Participants shall not contribute to the Plan.

(d) *Carryover.* To the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year unused benefits under a Participant's QSEHRA as of the end of the Plan Year. Except as otherwise provided in the Adoption Agreement, the benefit remaining unused as of the end of the Plan Year is determined after all Eligible Expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount will be used to increase the HRA reimbursement limit or the amount credited to an account-based HRA, as applicable, subject to the maximum benefit in Section 5.05(b). The total permitted benefit for an Eligible Employee, taking into account both carryover amounts and the newly available amounts, shall not exceed the maximum amount permitted by Code sections 9831(d)(2)(B)(iii) and 9831(d)(2)(D). Any unused benefit remaining in the Plan in excess of the benefit carried over as specified in the Adoption Agreement, if any, will be forfeited in accordance with Section 5.08. The carryover benefit may be used to pay or reimburse Eligible Expenses incurred during the Plan Year specified in the Adoption Agreement. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 5.06 ELIGIBLE EXPENSES

(a) *Eligible Expenses.* A Participant may be reimbursed from a QSEHRA for the expenses specified in the Adoption Agreement, provided that such expenses are not covered, paid, or reimbursed from any other source. The amount of reimbursements available under the Plan

shall be effectively available to all Eligible Employees.

(b) For purposes of determining whether an expense is eligible for reimbursement by the Plan as an Eligible Expense, the following applies:
(1) *Coverage of Adult Children.* To the extent provided in the Adoption Agreement, expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.
(2) *Long-Term Care Expenses.* Notwithstanding anything herein to the contrary, long-term care expenses shall not be Eligible Expenses if they are incurred by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner and the maximum amount of reimbursement reasonably available to a Participant for coverage under the QSEHRA is less than 500% of the value of the coverage.

(c) *Ineligible Expenses.* Expenses incurred by individuals who are not covered by this Plan when the expense is incurred are not eligible for reimbursement under the Plan.

Section 5.07 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from the Plan of Eligible Expenses incurred during the Plan Year, except as otherwise provided herein and in the Adoption Agreement.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement under the Plan during the Period of Coverage and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Proof of Coverage.* Prior to receiving any reimbursement from the Plan a Participant must provide proof of enrollment in health coverage that qualifies as "minimum essential coverage" under Code section 5000A(f) for the Plan Year with respect to each individual whose expenses are eligible for reimbursement before the first reimbursement of an expense of that individual. This proof of coverage requirement must be satisfied for each Plan Year in which a Participant intends to seek reimbursement for Eligible Expenses. The proof must consist of either: (i) a document from a third party showing that the Participant and the individual have coverage and an attestation by the Participant that the coverage is minimum essential coverage or (ii) an attestation by the Participant stating that the Participant and individual have minimum essential coverage, the date coverage began, and the name of the provider of the coverage. Following the initial proof of coverage, with each new request for reimbursement of an incurred expense for the same Plan Year, the Participant must attest that the Participant and the individual whose expense is being reimbursed continue to have minimum essential coverage. The Plan Administrator may set additional rules and conditions regarding this proof of coverage requirement as it deems appropriate. The Plan shall not reimburse a Participant who fails to provide the required proof of minimum essential coverage.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Plan. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the Plan of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(e) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of Eligible Expenses.

(f) *Excess Reimbursement.* If Participant receives a payment from the Plan that is in excess of the limit set forth in Section 5.05(d), the Participant shall repay the Plan the excess payment no later than the earlier of (1) March 15 following the Plan Year in which the excess payment was made and (2) the date that the Employer receives notification from the IRS that the payments under the Plan are under examination.

Section 5.08 FORFEITURE

Any QSEHRA benefit that remains unused at the end of any Plan Year that is not carried over in accordance with Section 5.05(d) (if applicable) shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the timeframe provided in the Adoption Agreement.

Section 5.09 TERMINATION OF COVERAGE

Except as provided in the Adoption Agreement, participation by a Covered Person in the Plan shall cease upon the date the individual fails to qualify as Covered Person and, in such case, expenses incurred after the date the individual fails to qualify as Covered Person are not eligible for reimbursement by the QSEHRA.

ARTICLE 6 NONDISCRIMINATION

Section 6.01 NONDISCRIMINATION REQUIREMENTS

The Plan may not discriminate in favor of highly compensated individuals as defined in Code section 105(h)(5) as to benefits provided or eligibility to participate.

Section 6.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 6.02 shall be carried out in a uniform and non-discriminatory manner.

Section 6.03 EXCEPTION FOR QSEHRA

Section 6.01 shall not apply to Qualified Small Employer Health Reimbursement Arrangements. A QSEHRA shall be provided on the same terms to all Eligible Employees of the Employer and its Affiliates.

ARTICLE 7 PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If the Plan is subject to ERISA, the Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan.

(b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:
- (1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;
- (2) to determine the amount, form, or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits under the Plan;
- (3) to determine the amount and manner of any allocations hereunder;
- (4) to maintain and preserve records relating to the Plan;
- (5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;
- (6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;
- (7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;
- (8) to determine all questions of the eligibility and of the status of rights of Participants;
- (9) to adjust Accounts in order to correct errors or omissions;
- (10) to determine the validity of any judicial order;
- (11) to retain records on elections and waivers by Participants;
- (12) to supply such information to any person as may be required; and
- (13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information

furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of its duties and responsibilities under the Plan.

(e) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA, to the extent that the Plan is subject to ERISA.

ARTICLE 8 AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time by the Plan Sponsor or its delegate. Any such amendment made by the Plan Sponsor or its delegate shall automatically apply to any other Employer participating in the Plan.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) A participating Employer's participation in this Plan shall terminate upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an Affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an Affiliate of the Plan Sponsor.

(c) To the extent the Plan is a QSEHRA, the Plan shall automatically terminate on the last day of the calendar year during which the Employer and its Affiliates become an Applicable Large Employer. In the event the Plan terminates under this Section 8.02(c), Participants may submit a request for reimbursement under the Plan for Eligible Expenses incurred prior to Plan termination and submitted no later than the date specified in the Adoption Agreement.

Section 8.03 PARTICIPATING EMPLOYERS

By virtue of its participation in the Plan, a participating Employer accepts, and agrees to be bound by, the terms and conditions of the Plan. The participating Employer consents to the Plan Sponsor's sole authority (without further signature or other action by the participating Employer) to amend or to terminate the Plan, to terminate the participating Employer's participation in the Plan, and to take all other actions within the authority of the Plan Sponsor.

ARTICLE 9 CLAIMS PROCEDURES

Section 9.01 CLAIMS

Plan claims shall be administered in accordance with 29 CFR 2560.503-1. Any claim shall be in writing and set forth the facts the Participant bringing the claim (the "Claimant") believes entitles him or her to the benefit claimed. Claims must be submitted to the Plan Administrator. For purposes of these claims procedures, electronic notification from the Plan Administrator serves as written notification in accordance with applicable Department of Labor regulations.

(a) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(b) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) reference to the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, including a statement that the Claimant may bring a civil action under section 502(a) of ERISA following an adverse benefits determination on review, and (E)(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(c) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination unless special circumstances require an extension of time for processing, in which case a decision shall be rendered within 120 days after the Plan Administrator's receipt of the request for review. If an extension of time is necessary because of special circumstances, the Plan Administrator shall give the Claimant written or electronic notice of the extension of time prior to the commencement of the extension.

(d) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) reference to the pertinent Plan provisions on which the denial is based, (C) 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 Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

(e) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. This exhaustion requirement applies to all types of claims under the Plan, including: (i) recovery of benefits under the Plan, (ii)

enforcement of your rights under the terms of the Plan, and (iii) clarification as to your rights to future benefits under the terms of the Plan. Unless otherwise provided under the Plan or required pursuant to applicable law, legal action for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 9.02 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any individual has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the individual, the Plan Administrator shall notify the individual and the individual shall repay such excess amount (or at the option of the Plan Administrator, the individual shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. An individual shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the individual fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the individual salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 10 MISCELLANEOUS

Section 10.01 NONALIENATION OF BENEFITS

No Participant shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments that he or she may expect to receive, contingently or otherwise, under the Plan.

Section 10.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any individual to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

Section 10.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any benefit or account other than as expressly authorized in the Plan.

(d) Benefits under the Plan shall be funded solely by assets of the Employer. Contributions to the Plan by Employees, directly or indirectly, are prohibited.

(e) This Plan is paid for solely by the Employer and is not provided pursuant to any salary- reduction election or otherwise under a Code section 125 cafeteria plan. Neither the Employee nor any other person has the right, currently or for any future year, to receive any benefit other than the reimbursement of substantiated eligible medical care expenses incurred by the Employee and the Employee's spouse and dependents.

Section 10.04 NO CASH OUT

The Plan shall not make payment to any individuals of unused benefits.

Section 10.05 DEATH

If a Participant dies, the Participant's beneficiaries may submit claims for Eligible Expenses for the portion of the Period of Coverage preceding the

date of the Participant's death, subject to the terms of the Plan. A Participant may designate a specific beneficiary provided that such beneficiary is the Participant's spouse or one or more of the Participant's dependents. Any such beneficiary designation shall be in a form prescribed by the Plan Administrator and will be effective only when filed as directed by the Plan Administrator during the Participant's lifetime, and shall be subject to and conditioned upon any and all provisions of federal law regarding the choice of beneficiary. Each properly filed beneficiary designation will cancel all previously filed beneficiary designations. If no beneficiary is specified (or if the beneficiary designation is invalid for any reason), the Plan Administrator may pay any amount due hereunder to the Participant's spouse or, if there is no spouse, to the Participant's dependents in equal shares or, if there are no spouse or dependents, to the estate of the Participant. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

Section 10.06 COBRA

If the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 10.07 NO GUARANTEE OF TAX CONSEQUENCES

The Plan Administrator and the Employer do not make any guarantee that the amounts paid to the Participant hereunder will be excludable from the Participant's gross income for federal, state, or local tax purposes.

Section 10.08 PLAN PROVISIONS CONTROL

In the event that the terms of any summary or description of the Plan conflict or are inconsistent in any way with the terms of the Plan, the provisions of the Plan shall control.

ARTICLE 11 HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 11 shall only apply to the Integrated HRA described in Section 3 of the Plan and the QSEHRA described in Section 5 to the extent either constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. References to "Plan" for purposes of this Article 11 shall be limited to group health plan benefits only.

Section 11.01 DEFINITIONS

For purposes of this Article 11, the following terms have the following meanings:

(a) Business Associate means
any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means
benefits offered under the Plan that constitute a group health plan as defined in section 2791(a)(2) of the Public Health Service Act.

(c) Individual means
the Participant enrolled in any of the Group Health Benefits under the Plan or a Participant's covered dependent.

(d) Notice of Privacy Practices means
a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means
the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information or PHI means
information about an individual, including genetic information (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan;
(2) relates to the past, present or future physical or mental health or condition of the individual, the provision of health care to the individual, or the past, present or future payment for the provision of health care to the individual; and
(3) identifies the individual or with respect to which there is a reasonable basis to believe the information may be used to identify the individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means
information summarizing the claims history, claims expenses, or types of claims experienced by an individual, and from which the following information has been removed:
(1) names;
(2) any geographic information which is more specific than a five-digit zip code;
(3) all elements of dates relating to a covered individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered individual if the individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
(5) facial photographs or biometric identifiers (e.g., finger prints); and
(6) any other unique identifying number, characteristic, or code.

Section 11.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.
(1) The Plan or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
(B) for auditing claims payments made by the Plan;
(C) to request proposals for services to be provided to or on behalf of the Plan; and
(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.
(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.
(3) The Plan may disclose to the Plan Sponsor information regarding whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.
(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.
(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.
(3) The Plan Sponsor will not use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
(5) The Plan Sponsor will make a covered individual's PHI available to the covered individual in accordance with the Privacy Rule.
(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.
(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and

allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor who are identified in the Plan's HIPAA Policies and Procedures may be given access to PHI received from the Plan or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining health insurance coverage or premium bids for health plans.

(2) The Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to Business Associates of the Plan.

Section 11.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) 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;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.