The EBC HRA℠

Plan Document

 404-0110 10/22

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ABOUT THE PLAN DOCUMENT

The *Plan Document* is the legal outline of your plan and follows your plan setup as specified in the *Plan Adoption Agreement*, incorporated by reference herein. All references to the *Plan Adoption Agreement* shall be interpreted to include any addenda or subsequent amendments to the *Plan Adoption Agreement*, which shall be reflected in the *My Company Plan* provided to employees as part of the *Summary Plan Description.*

In the case of any conflict between this *Plan Document*, the *Summary Plan Description*, and/or any other reference materials provided to you or your Participants, this *Plan Document* controls. You should keep your *Plan Document* available at all times and, when necessary, use it as a reference tool. You must make the *Plan Document* available to your EBC HRA Participants upon request.

ARTICLE 1 - PURPOSE

This document, together with the *Plan Adoption Agreement* as completed and adopted by the Employer, sets forth the Health Reimbursement Arrangement, hereinafter referred to as the "EBC HRA℠" or the "Plan." The purpose of the Plan is for the Employer to provide reimbursement to participating employees for expenses they incur for the medical care of themselves, their spouses, and their dependents.

ARTICLE 2 - DEFINITIONS

Section 2.1: **Administrator** means the Employer or a person or entity appointed by the Employer to function in this capacity.

Section 2.2: **Affiliate** means an entity (other than the Employer), which for purposes of Code § 105 or 106, is required to be aggregated with the Employer as if the employees of the Affiliate and the Employer were employed by a single employer. For example, Affiliates include entities which, along with the Employer, are members of a group of businesses under "common control" as defined in Code § 414(b) or (c), or an "affiliated service group" as defined in Code § 414(m).

Section 2.3: **Benefits Card** means a prepaid debit card.

Section 2.4: **COBRA** means the group health plan continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time.

Section 2.5: **Code** means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.6: **Coverage Level** means the category of coverage a Participant is enrolled in, as determined by the number of individuals who may have Eligible Expenses reimbursed by the Plan. A Participant's Coverage Level must be consistent across all portions of their Integrated Medical Plan enrollment. For example, a Single Coverage Level only provides reimbursement for a Participant, and not their Spouse, Dependent, or Eligible Child. Refer to the *Plan Adoption Agreement* for the Coverage Levels offered under the Plan.

Section 2.7: **Dependent** means dependent as defined in Code § 152. Any child of divorced parents shall be treated as a Dependent of both parents if all of the following conditions are met:

(a) more than one-half of the child's support during the calendar year comes from one or both parents;

(b) the child is in the custody of one or both parents for more than one-half of the calendar year; and

(c) the child qualifies under Code § 152(c) or § 152(d) as a qualifying child or qualifying relative of one of the parents.

Section 2.8: **Eligible Child** means a child as defined in Code § 152(f), if the child has not attained age 27 as of the end of the calendar year.

Section 2.9: **Eligible Employee** means an Employee eligible to participate in this Plan. Refer to the *Plan Adoption Agreement* for the Eligibility Requirements of the Plan.

Section 2.10: **Eligible Expense** means an expense falling under any Eligible Expense Type reimbursable under the Plan. Nevertheless, an Eligible Expense shall not include an expense for which the Participant can obtain reimbursement under any other health plan, insurance policy, or government program.

Section 2.11: **Eligible Expense Type** means a category of Eligible Expenses that the Employer has determined is reimbursable under the Plan in the amounts and at the tiers specified in the *Plan Adoption Agreement*, and which a Participant incurs for "medical care," as defined in Code §§ 105(b), 106(f), and 213(d), for the Participant or his or her Spouse, Dependent or Eligible Child.

Section 2.12: **Employee** means an individual who is on the Employer's Form W-2 payroll. Employee does not include any individual not on the Employer's Form W-2 payroll, even if a governmental agency or a court later determines that he/she is a common-law employee who should have been included on the Employer's Form W-2 payroll. The preceding notwithstanding, to the extent provided for by the Employer, Employee may include an individual who was on the Employer's Form W-2 payroll (i.e., former employees, retirees). Employee does not include sole proprietors, partners in a partnership, members of an LLC taxed as a partnership, more-than-2% shareholders of a Subchapter S Corporation, or any other individual considered "self-employed".

Section 2.13: **Employer** means the entity listed in the *Plan Adoption Agreement*. The Plan is maintained by the Employer for the benefit of its employees and for the benefit of employees of employers which are affiliated with the Employer and which adopt the Plan with the consent of the Employer (as named in an Addendum to the *Plan Adoption Agreement*). Unless indicated otherwise by the context in which it is used, the word "Employer" refers to each such employer, not just the primary employer that executes this document.

Section 2.14: **Entry Date** means the first day on which the Employee becomes a Participant by meeting the requirements set forth in the Article titled *Eligibility and Participation.*

Section 2.15: **ERISA** means Employee Retirement Income Security Act of 1974, as amended from time to time. If the Employer is a governmental entity or church-controlled entity whose employee benefit plans are "governmental plans" or "church plans" and thereby exempt from Title I of ERISA, then the Plan shall likewise be exempt.

Section 2.16: **Highly Compensated Individual** means an individual who is

(a) one of the 5 highest-paid officers,

(b) a shareholder who owns (with application of the ownership attribution rules of Code §318) more than 10% in value of the stock of the Employer, or

(c) among the highest-paid 25% of all Employees (other than excludable Employees who are not eligible to become Participants).

Section 2.17: **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and any other state law to the extent applicable, as amended from time to time.

Section 2.18: **Integrated Medical Plan** means a group health plan that is integrated with the EBC HRA in accordance with Treas. Reg. §54.9815-2711(d).

Section 2.19: **Annual Benefit Amount** means the amount of money made available by the Employer to each Participant during the Plan Year for Eligible Expenses incurred by a Participant, their Spouse, Dependent, or Eligible Child (depending on Coverage Level). The Annual Benefit Amount is defined in the Plan Design section of the Employer's *Plan Adoption Agreement*. The Annual Benefit Amount shall be based upon a full 12-month Plan Year unless otherwise stated.

Section 2.20: **Participant** means an Eligible Employee who becomes and remains a Participant under the Article titled *Eligibility and Participation*.

Section 2.21: **Plan Year** means the period defined in the *Plan Information* section of the *Plan Adoption Agreement.*

Section 2.22: **Spouse** means a person to whom an individual is legally married under the laws of a state or country.

ARTICLE 3 - ELIGIBILITY AND PARTICIPATION

Section 3.1: **Commencement of Participation.** An Eligible Employee shall begin to participate as of the first Entry Date after he or she completes any waiting period and enrolls in the plan as defined in the EBC HRA Eligibility and Participation section of the *Plan Adoption Agreement.*

For purposes of this Section:

(a) An Employee may enroll in the plan either through an active enrollment or through the Employer's policy of automatic enrollment based on participation in the employer's Integrated Medical Plan.

(b) An Employee whose employment terminates before he or she completes any period of service required for participation shall:

(1) lose credit for such service and be treated as a new Employee upon any subsequent reemployment; and

(2) his or her period of service for an Affiliate or predecessor of the Employer shall be treated as a period of service for the Employer.

Section 3.2: **Change of Coverage or Coverage Level.** This HRA is coupled with one or more Integrated Medical Plans, such that an Eligible Employee's enrollment in the EBC HRA is contingent upon their enrollment in an approved Integrated Medical Plan. Therefore, any coverage change made to the Integrated Medical Plan, such as enrollment, disenrollment, or change of coverage level (for example, from single to family coverage), must be made for the EBC HRA portion of coverage. No coverage change may be permitted for the EBC HRA that is not made for the Integrated Medical Plan.

Section 3.3: **Opt Out.** Effective as of the beginning of any calendar month, or upon termination of employment from the Employer, a Participant may, by written notice to the Employer (which shall forward such written notice to Employee Benefits Corporation) opt out of and waive future reimbursements from the Plan for the remainder of the Plan Year.

Section 3.4: **Termination of Participation.** Except as otherwise required by law, a Participant ceases to be a Participant in this Plan on the earliest of:

(a) the date on which the Participant is no longer is an Eligible Employee;

(b) the date on which the Participant no longer participates in the Integrated Medical Plan; or

(c) the date on which the Employer effectively terminates the Plan.

Section 3.5: **Reemployment.** If an Employee's employment terminates before he or she becomes a Participant, then he or she shall lose credit for such period of employment and be treated as a new Employee upon any reemployment. If an Employee's employment terminates after he or she becomes a Participant, then he or she shall become a Participant again immediately upon reemployment.

Section 3.6: **FMLA Leave.** Notwithstanding any contrary provision in this Plan, if a Participant is on FMLA Leave, then to the extent required by FMLA, the Employer shall continue to maintain coverage under the Plan on the same terms and conditions as if the Participant were still an active Employee.

Section 3.7: **Non-FMLA Leave.** When a Participant goes on a non-FMLA leave of absence, the Employer's usual procedures with respect to benefits while on leave apply.

ARTICLE 4 - BENEFITS OFFERED UNDER THE PLAN

Section 4.1: **Expenses Eligible for Reimbursement.** The Employer shall provide reimbursement for any Eligible Expense incurred during the Plan Year for any participant who

properly and timely requests reimbursement. In the event a Participant has an available balance in a Health Care FSA offered by the Employer, any expenses incurred by the Participant that could be reimbursed by either the Health Care FSA or the EBC HRA shall be reimbursed from the EBC HRA first, or otherwise according to the participant's direction. Expenses reimbursed by another plan are not eligible for reimbursement from the EBC HRA.

Section 4.2: **HRA Rollover.** The Employer allows Participants to accumulate funds from a prior Plan Year. Accumulated funds may or may not be made available to Participants to reduce the amount the Participant would otherwise be responsible for paying within a particular tier of coverage, or after the maximum Annual Benefit Amount has been exhausted for an Eligible Expense Type. If rollover is not available for Participants to use to reduce the amount they would otherwise be responsible for paying, such amounts will be accumulated for each employee for future use according to the Employer's policies. Refer to the *Plan Adoption Agreement* for rollover limits and payment tiers to which rollover applies, if any.

If rollover funds are applied to a payment tier, Eligible Expenses shall be reimbursed first from the funds available for the Plan Year in which the expense is incurred. Eligible Expenses will be reimbursed from rollover amounts only when such funds have been exhausted.

(a) **Forfeiture of Amounts Not Rolled Over.** Any balance remaining in a Participant's HRA at the end of the Plan Year that exceeds the limitations specified by the Employer in the Section regarding rollover in the *Plan Adoption Agreement*, shall be forfeited to the Employer at the end of the Runout Period.

(b) **No Effect on Runout Period.** The availability of a rollover amount shall have no effect on the Runout Period under this Plan, as explained in the Section titled *Timing of Reimbursement Application* in the Article titled *Reimbursement Rules*.

Section 4.3: **Additional Benefits.** The Employer allows Participants who meet certain criteria to receive an allocation to their HRA that exceeds any Annual Benefit Amount. The additional benefit allocation is made available to Participants to reduce the amount the Participant would otherwise be responsible for paying within a particular tier of coverage, or after the Annual Benefit Amount has been exhausted for an Eligible Expense Type. Refer to the *Additional Benefit Addendum* to the *Plan Adoption Agreement* for information about the Employer's criteria to receive these funds.

Section 4.4: **Maximum Benefit Available.** Such reimbursements in any Plan Year shall not exceed the Annual Benefit Amount plus any amounts paid from the rollover of funds from a prior year, or from additional benefit dollars deposited by the Employer.

ARTICLE 5 - REIMBURSEMENT RULES

Section 5.1: **Incurrence of Expense:** An Eligible Expense is incurred at the time the goods or services causing the expense are furnished, not when the expense is billed or paid.

Section 5.2: **Form of Reimbursement Application.** The application for reimbursement shall be in a form acceptable to the Administrator and shall include:

(a) the name of the person on whose behalf the expenses were incurred;

(b) a description of the expenses incurred;

(c) the date(s) services were incurred;

(d) the amount of the requested reimbursement; and

(e) a statement that the expenses have not otherwise been paid (and are not expected to be paid) from any other source.

(1) The information required must be substantiated from an independent third party, for example, an Explanation of Benefits (EOB) from a health care provider or an itemized receipt. Some Eligible Expense Types require submission of an EOB; see *My Company Plan* to confirm if an EOB is required.

Section 5.3: **Benefits Card.** An employee may use the Benefits Card to pay for Eligible Expenses if all of the following conditions are met:

(a) the card is used to pay for Eligible Expenses at a health care provider office, or a retailer or pharmacy that utilizes Inventory Information Approval System (IIAS) technology to enable automatic substantiation at the point of sale;

(b) the Participant submits documentation meeting the requirements outlined in the Section titled Form of Reimbursement Application to the Administator upon request for all expenses that cannot be automatically substantiated at the point of sale. If adequate documentation is not submitted in a timely manner, the Administrator shall:

(1) Seek repayment or an offsetting expense from the Participant for any expense for which sufficient documentation is not submitted, and

(2) Deactivate the Participant's use of the card until such time as the ineligible expense is repaid or otherwise settled by the Employer in accordance with Treas. Reg. § 1.125-6(d)(7).

Section 5.4: **Reimbursement of Insurance Premiums.** The Plan reimburses as an Eligible Expense premiums paid by an employee for individual insurance coverage under a dental, vision, cancer or critical illness (other than an indemnity policy) or long-term care insurance policy (up to applicable annual limits) as long as the premiums have been paid by the Participant on an after-tax basis. Individual medical insurance premiums, including prescription drug, Medicare, or Medicare supplemental policies cannot be reimbursed unless the EBC HRA provides benefits to former employees only.

Group insurance premiums, such as COBRA coverage or coverage offered by a spouse's employer, can only be reimbursed if the Participant can provide sufficient substantiation that the premiums were paid on an after-tax basis. Payroll stubs are not considered sufficient substantiation unless they clearly show that payroll tax was applied to the premium.

Section 5.5: **Timing of Reimbursement Applications.** Applications for reimbursement of expenses incurred during the Plan Year shall be submitted to the Administrator prior to the end of the Runout Period determined by the Administrator in the *Plan Adoption Agreement* for any Plan Year.

Section 5.6: **Facility of Payment.** The Employer may provide reimbursement of an Eligible Expense to a representative of the Participant (such as a parent or legal guardian) instead of to the Participant when:

(a) the Participant is a minor or incapacitated and thereby unable to manage his or her financial affairs, and

(b) the representative properly and timely requests reimbursement of the Eligible Expense for the Participant.

Section 5.7: **Direct Payment.** The Employer may, in its discretion, directly pay the provider of the medical care for a Participant's Eligible Expense instead of reimbursing the Participant.

Section 5.8: **End of Period Balance.** Any balance remaining in a Participant's HRA at the end of the Plan Year that exceeds the limitations specified by the Employer in the Section regarding rollover in the *Plan Adoption Agreement*, shall be forfeited to the Employer at the end of the Runout Period.

Section 5.9: **Post-Termination Expenses.** Expenses incurred during the period of coverage before termination of participation may only be reimbursed post-termination if application for reimbursement of such expenses is made within the Runout Period for Mid-Year Terminations as specified in the *Plan Adoption Agreement*, unless the Participant is eligible for and elects COBRA for both the Integrated Medical Plan and the HRA, thereby extending the period of coverage for the duration of the COBRA coverage period. No reimbursement shall be made for any expense incurred after participation in the applicable part of the Plan has terminated for any reason.

Section 5.10: **Recoupment of Overpayments or Erroneous Payments.** To the extent that the Plan has made a reimbursement to a Participant that is later determined to be an overpayment, an erroneous payment, or a payment which cannot be substantiated, the Administrator shall have the power and discretion to offset such overpayment against future reimbursements. If no further reimbursements are forthcoming, the Administrator may demand repayment from the Participant and include, or direct the Employer to include, the amount of overpayment as IRS Form W-2 compensation to the Employee.

ARTICLE 6 - PLAN ADMINISTRATION

Section 6.1: **Plan Administrator.** The Plan shall be administered by the Employer. The Employer shall discharge its duties with respect to the Plan solely in the interest of the Participants and their Spouses, Dependents and Eligible Children and for the exclusive purpose of providing benefits to them and defraying reasonable expenses of administering the Plan. The Employer may adopt such rules, as it deems necessary or appropriate for administration of the Plan.

Section 6.2: **Discretionary Authority of Employer.** The Employer shall pay benefits under the Plan only if the Employer decides in its discretion that the applicant is entitled to them.

Section 6.3: **Record Retention.** The Employer shall maintain records of the Eligible Expenses that are reimbursed for the current Plan Year and the most recent six Plan Years. The Employer shall make available to each Participant the records of the reimbursements made to him or her for those years.

Section 6.4: **Service Provider.** The Employer may engage third parties, such as Employee Benefits Corporation, to provide certain services to the Employer. The obligations of any third party shall be limited to providing such services as agreed to between the third party and the Employer. Under no circumstances shall Employee Benefits Corporation become the administrator of the Plan or have any discretionary authority under the Plan.

Section 6.5: **Funding the Plan:** All benefits payable under the Plan shall be paid from the general assets of the Employer. No funds are required to be set aside for the payment of benefits. To the extent any funds are set aside, they shall be subject to claims of general creditors of the Employer. Funds held by any service provider for the payment of benefits under the Plan shall be assets of the Employer, subject to claims of general creditors of the Employer. Any reference to an account, deposits, or funds made herein as applied to a Participant shall refer only to a recordkeeping ledger and the Participant shall have no rights vested in amounts not distributed.

Section 6.6: **ERISA Consequences.** To the extent the Employer is subject to ERISA, the EBC HRA is a "welfare plan" as defined in ERISA § 3(1). Therefore, unless the Plan is a "governmental plan" or "church plan" or otherwise exempt from Title I of ERISA, the Administrator is required to comply with Title I of ERISA.

Section 6.7: **Annual Report (Form 5500).** The Employer shall file an annual report (Form 5500) for the Plan only if required by Title I of ERISA and applicable Department of Labor regulations.

ARTICLE 7 - COMPLIANCE WITH LAWS

Section 7.1: **Compliance with Income Exclusion Rules.** The Plan is intended to be a health plan for purposes of Code §§ 105 and 106. The Plan shall be administered and interpreted consistent with that purpose. Reimbursements under the Plan are accordingly intended to be excluded from the gross income of Participants as provided under Code § 105(b), except to the extent the plan is found to be out of compliance with the nondiscrimination rules set forth in Section 7.2. In any year in which the Plan is found to be or is reasonably expected to be out of compliance with the nondiscrimination rules outlined in Section 7.2, the Plan Sponsor shall ensure the Plan corrections are taken, including adjusting the taxable income of any Highly Compensated Individuals to include some or all benefits they receive under the Plan. Similarly, as long as the plan is found not to be discriminatory under Section 7.2, coverage under the Plan is accordingly intended to be excluded from the gross income of Participants as provided under Code § 106.

Section 7.2: **Compliance with Nondiscrimination Rules.** The Plan is intended to comply with Code § 105(h) and shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate and as to benefits.

Section 7.3: **Compliance with COBRA.** To the extent required by law, the Plan shall comply with Part 6 of ERISA and parallel requirements under the Internal Revenue Code and the Public Health Service Act regarding continuation coverage of individuals after "qualifying events" such as termination of employment.

Section 7.4: **HIPAA.**

(a) Privacy and Security: Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

(1) General. Unless otherwise permitted by law, and subject to the conditions of disclosure described below, the Plan or a business associate on behalf of the Plan may disclose PHI and Electronic PHI to Employer, provided that Employer is permitted to use or disclose PHI and Electronic PHI only for Plan Administration purposes. Plan Administration means administration functions performed by Employer on behalf of the Plan, such as quality assurance, appeal adjudication, auditing, monitoring, and Plan management. Plan administration functions do not include functions performed by Employer in connection with any other benefit or benefit plan of Employer or any employment-related actions or decisions. Notwithstanding any provisions of this Plan to the contrary, in no event shall Employer be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

(2) Conditions of Disclosure. Employer agrees that with respect to any PHI (other than PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) disclosed to it by the Plan or a business associate on behalf of the Plan, Employer shall:

a. not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

b. ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to Employer with respect to PHI;

c. not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer; report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

d. make available all PHI necessary for the Plan to comply with an individual's right to access PHI in accordance with 45 CFR §164.524, including the right to access electronic copies of PHI, if applicable;

e. make available PHI required for the Plan to comply with an individual's right to amend PHI, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

f. make available PHI required for the Plan to comply with an individual's right to request an accounting of disclosures in accordance with 45 CFR §164.528;

g. make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

h. if feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, 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 PHI infeasible; and

i. ensure that adequate separation between Plan and Employer (i.e., a firewall) is established.

Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than Electronic PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) on behalf of the Plan, it 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 between the Plan and Employer (i.e., the firewall) is supported by reasonable and appropriate security measures;

c. ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

d. report to the Plan any security incident of which it becomes aware.

(3) Inapplicability to Enrollment, Disenrollment, and Summary Health Information. This provision does not apply to enrollment and disenrollment information created by Employer, or to summary health information as that term is defined under 45 CFR 164.504.

(4) Adequate Separation Between Plan and Employer. Employer shall allow employees with oversight responsibility for the Plan access to the PHI. No other persons shall have access to PHI. This class of employees shall have access to and use of PHI only to the extent necessary to perform the plan

administration functions that Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this Amendment, the employee shall be subject to disciplinary action by Employer for noncompliance pursuant to Employer's employee discipline and termination procedures. Employer shall ensure that the provisions of this Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated herein create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

(5) Certification of Employer. The Plan shall disclose PHI to Employer only upon the receipt of a certification by Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Employer agrees to the conditions of disclosure set forth above.

(b) Portability: Unless the Plan is an excepted benefit, the Plan shall comply with the HIPAA group market portability rules. The Plan is an excepted benefit if the coverage provided under the Plan is not limited to benefits that are excepted benefits as defined by HIPAA.

Section 7.5: **Other.** To the extent required by law, the Plan shall comply with Part 7 of ERISA and parallel requirements under the Internal Revenue Code and the Public Health Service Act, as applicable, including provisions regarding parity in mental-health benefits, benefits for mothers and newborns, and treatment of expenses for post-mastectomy reconstructive surgery.

ARTICLE 8 - CLAIMS PROCEDURES

Section 8.1: **Approval/Denial of Applications.** Within a reasonable period of time after the Administrator receives a reimbursement (or other benefit) application (but in any case within 30 days after receipt), the Administrator shall either approve or deny the application and, if approved, make the reimbursement, or if denied, notify the Participant of the denial. The Administrator may extend the 30-day period once for up to 15 days, if the Administrator:

(a) determines that the extension is necessary due to circumstances beyond the control of the Administrator; and

(b) notifies the applicant of those circumstances and the date by which the Administrator expects to render a decision before the expiration of the initial 30-day period.

Section 8.2: **Manner of Providing Denials.** If a reimbursement (or other benefit) application is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

(a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;

(b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant’s right to request and receive, free of charge, a paper copy of the denial; and

(c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

Section 8.3: **Content of Denials.** A denial shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner):

(a) Information sufficient to identify the claim including the date of service, the health care provider, and the claim amount (if applicable);

(b) the specific reason for the denial;

(c) reference to the specific Plan provisions upon which the denial is based;

(d) a description of any additional material or information necessary for the applicant to perfect the application (and an explanation of why such material or information is necessary);

(e) a statement describing the appeal procedures below, any external review rights, and the time limits applicable to such procedures, including a statement of the applicant's right to bring a civil action following an adverse decision on appeal;

(f) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial;

(g) a description of any Plan standard relied upon for the denial; and

(h) information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

Section 8.4: **Appeals.** A denial may be appealed by notifying the Administrator within 180 days following receipt of the denial.

Section 8.5: **Decisions on Appeals.** Within a reasonable period of time after the Administrator receives an appeal (but in any case within 60 days after receipt), the Administrator shall have the appeal decided by a decision maker who shall not afford deference to the initial denial and who is not the individual (or a subordinate of the individual) who made the denial. The appellant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal. The appellant shall be provided, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the appeal. The decision maker shall take into account all comments, documents, records, and other information relating to the appeal, without regard to whether such information was submitted or considered in the initial denial.

Section 8.6: **Manner of Providing Adverse Decisions on Appeals.** If an appeal is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

(a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;

(b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant's right to request and receive, free of charge, a paper copy of the denial; and

(c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

Section 8.7: **Content of Adverse Decisions on Appeals.** An adverse decision on an appeal shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner):

(a) Information sufficient to identify the claim including the date of service, the health care provider, and the claim amount (if applicable);

(b) the specific reason for the decision and a discussion of the decision;

(c) reference to the specific Plan provisions upon which the decision is based;

(d) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial;

(e) a description of any available external review process;

(f) a statement of the right to sue in federal court;

(g) a statement that the applicant 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 appeal; and

(h) information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

Section 8.8: **Second Level Appeals.** If a participant disagrees with an adverse decision on an appeal, the participant may submit a second level appeal to the Administrator by notifying the Administrator within 60 days following receipt of the adverse decision on the appeal. The provisions outlined in Sections under this Article titled *Decisions on Appeals* through *Content of Adverse Decisions on Appeals* shall apply to second level appeals.

Section 8.9: **Compliance with Law.** The claims and appeals process will be applied in a manner that complies with all applicable laws and regulations, including regulations under the Patient Protection and Affordable Care Act (PPACA) of 2010.

Section 8.10: **Limitation on Claims.** To the extent that a Participant is affected by any denial of a benefit under this Plan, including any benefit covered by ERISA, legal action may not be taken by any Participant against the Plan or Administrator until after all administrative procedures outlined in this Plan Document have been exhausted. Once such procedures have been exhausted, no legal claim may be filed after 12 months following the date the Adverse Decision on Appeal is provided to Participant.

ARTICLE 9 - AMENDMENT OR TERMINATION

Section 9.1: **Amendment.** The Employer may at any time amend the Plan in writing.

Section 9.2: **Changes to Maintain Compliance.** The Employer shall take any appropriate action to maintain the Plan's compliance with Code §§ 105 and 106. Such action may include, without limitation, a reduction of benefits without the consent of Participants.

Section 9.3: **Termination.** The Employer may at any time terminate the Plan.

ARTICLE 10 - MISCELLANEOUS

Section 10.1: **Nonalienation of Benefits.** A Participant's right to reimbursement under the Plan shall not be alienated, assigned, encumbered, or otherwise transferred in any manner.

Section 10.2: **Subrogation and Refund.**

(a) The Plan has the right to seek recovery from an individual for any reimbursements or payments that have erroneously been or are later paid for or reimbursed by another plan or other third party, for any reason.

(b) If an individual is reimbursed under this Plan for medical expenses incurred due to illness or injuries caused by the act or omission of a third party, the individual:

(1) automatically assigns to the Plan any rights he or she has to recoveries from the third party up to the full amount of the reimbursements and

(2) must repay to the Plan the reimbursements paid on his or her behalf out of any recovery.

(c) This subrogation right allows the Plan to pursue any claim that the individual has against any third party, whether or not the individual chooses to pursue that claim. The Plan may make a claim directly against the third party, but in any event, the Plan has an equitable lien on any amount of the individual's recovery, whether or not designated as payment for medical expenses. By accepting reimbursements under this Plan, the individual agrees to hold recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. If the individual dies as a result of his/her injuries and a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and refund rights shall apply.

(d) This Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a recovery unless a covered individual has been made whole with regard to illness or injury that is the responsibility of a third party. This Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this Plan, because the Plan's refund rights apply to the first dollars payable by a third party.

(e) To carry out the terms of this section, all individuals covered by the Plan are required to cooperate with the Administrator, and, in particular, are required to:

(1) Cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or providing testimony at trial;

(2) Provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;

(3) Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(4) Do nothing to prejudice the Plan's rights of subrogation and refund;

(5) Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and

(6) Not settle or release, without the prior consent of the Plan, any claim to the extent that the individual may have recovery rights against any third party.

(f) If the covered individual and/or his or her attorney fail to reimburse the Plan for all benefits paid or to be paid from any recovery, the individual will be responsible for any and all expenses (including attorney fees and costs) associated with the Plan's attempt to recover such money from the individual or a third party. If a covered individual refuses to cooperate with the Plan's subrogation and refund rights, or refuses to execute and deliver such papers as the Plan may require in furtherance of its subrogation and refund rights, the Plan has no obligation to pay benefits to him/her. If the covered individual is a minor, the Plan has no obligation to pay any medical benefits incurred on account of injury or illness caused by a third party until after the individual or his/her authorized legal representative obtains valid court recognition and approval of the Plan's 100% first-dollar subrogation and refund rights on all recoveries. If an individual (and/or his/her attorney) fails to comply with this section, the Plan may withhold benefits otherwise payable to the individual until he/she satisfies his/her obligation under this section.

Section 10.3: **No Implied Rights.** Participants and their Spouses, Dependents and Eligible Children shall have no rights under the Plan other than as specifically set forth in the Plan. In particular, the Plan shall not provide Participants with any employment rights.

CERTIFICATE OF RESOLUTION

The undersigned as an authorized representative of (Legal Name of Organization Sponsoring the Plan)**:**

_____ **(the**

"Employer") hereby certifies that on (Date of Adoption):_____**, the**

Employer adopted the following resolution (Check only one option below):

_____ **This is an entirely new Section 105 Health Reimbursement Arrangement:**

WHEREAS, the Employer desires to offer to its employees an Internal Revenue Code section 105 health reimbursement arrangement ("the Plan").

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby establishes the cafeteria plan set forth in the attached plan document prepared by Employee Benefits Corporation and presented to the Employer.

BE IT FURTHER RESOLVED, that the individuals who manage the Employer hereby are authorized and directed to execute the plan document and related documents (such as a service agreement with Employee Benefits Corporation) on behalf of the Employer and take such other actions as are necessary or appropriate to carry out the above resolution.

_____ **This is a restatement of a previously established Section 105 Health Reimbursement Arrangement:**

WHEREAS, the Employer previously established (and currently maintains) for the benefits of its employees and their beneficiaries an Internal Revenue Code section 105 health reimbursement arrangement ("the Plan") with the name of:

_____

Legal Plan Name

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby amends and restates the Plan as set forth in the attached plan document prepared by Employee Benefits Corporation and presented to the Employer.

BE IT FURTHER RESOLVED, that the individuals who manage the Employer hereby are authorized to execute the amended and restated plan document and related documents (such as a service agreement with Employee Benefits Corporation) on behalf of the Employer and take such other actions as are necessary or appropriate to carry out the above resolution.

Please Sign and Date the Document

_____ _____

Signature Date

_____ _____

Print Name Title

